MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

00693

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 days
Hospital, Institution, or street address where death occurred:
8600 Old Georgetown Rd. Bethesda Md.
How long in hospital or institution? 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3922 Oliver St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Emily Farr Anderson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
F	W	m

6.(b) Name of husband ~~or wife~~ R. Earl Anderson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 5, 1880

8. AGE: Years	Months	Days	If less than one day
65	6	2	..... hrs. ..... min.

9. Birthplace Lawrenceville, New Jersey
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name William Farr
13. Birthplace ? New Jersey

MOTHER
14. Maiden name Jane Hays
15. Birthplace ? New Jersey

16. Informant Mrs. R. Earle Anderson
Address 3422 Oliver St. Ch. Ch. Md.

17. Disposition (Burial, cremation, or removal. Which?) Date thereof 1/9/46 (month) (day) (year)
Cemetery or crematory The Princeton Cemetery
Location Princeton, N. J.
18. Funeral director Wm Reuben Humphreys
Address 7557 Wis. Ave. Bethesda
19. 1/8 1946 Wm Edbest Md Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 1946, at 8:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1945 to Jan 7 1946
and that I last saw h alive on Jan 6 1946

Immediate cause of death Pulmonary embolism — DURATION: 7 min

Due to Thrombosis of iliac vein — 24 hours

Burns were accidental. C. of D.

Due to 2d degree burns of face, neck, arms and hands — 27 days

Other conditions Coronary thrombosis — 3½ mos

Patient slipped on floor and fell into fireplace, where she was burning papers.
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Pulmonary embolus
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) at home
Means of injury Injured at work?

23. SIGNATURE John P. Logan M.D.
M. D. or other
Address 6001 Nevada Ave NW Date signed Jan 7-1946

VS A15 9.45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

00694

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg Co,
City or town: Gaithersburg, Md, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg
City or town: Gaithersburg Md, rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Everett Summerfield Andrews

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 13th 1862

8. AGE: Years	Months	Days	If less than one day
1862 83	11	18	hrs. min.

9. Birthplace: Clarksburg Md, (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: James Wm Andrews
13. Birthplace: Md

MOTHER
14. Maiden name: Letha Reed
15. Birthplace: Md

16. Informant: Girtrude Andrews
Address: Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/3/46 (month) (day) (year)
Cemetery or crematory: Neelsville, Cemetery
Location: Neelsville, Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Feb 1 1946 (Date rec'd by registrar) Alsuda L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 19 46 at 11.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 1 - 1945, to Jan - 31 - 1946 and that I last saw him alive on Jan 31 - 1946

Immediate cause of death	DURATION
Cardio-nephritis	10 mo-
Due to: Senility -	5 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William C Miller M.D. M. D. or other
Address: Gaithersburg Md Date signed 2/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

00695

Reg. Dist. No. 212

1. PLACE OF DEATH:
County Montgomery
City or town Barnesville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Boyd
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma Barr

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Wm L. Barr
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 5 - 1866

8. AGE: Years	Months	Days	If less than one day
79	4	2	..... hrs. ..... min.

9. Birthplace Steetton, Pa
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business
12. FATHER Name John Whitman
13. Birthplace Pa.
14. MOTHER Maiden name Unknown
15. Birthplace
16. Informant Bryon Barr
Address Barnesville, Md
17. Burial Date thereof 1/9/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville, Md
18. Funeral director William B. Hilton
Address Barnesville, Md
19. Jan. 8 1946 Mrs. C. C. Hilton
(Date rec'd by registrar) By Mrs. W.B.H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7 - 1946, at 10 25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/6 1945, to 1/7 1946
and that I last saw h alive on 1/6 1946

Immediate cause of death	DURATION
Cardio-renal-vascular disease	5 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. D. White, M.D.
M. D. or other
Address Poolesville, Md. Date signed 1/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00696

Reg. Dist. No. 212

FILM No. I 00 JAN 21 1946

1. PLACE OF DEATH:
County: Montgomery
City or town: Boyd - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County:
City or town: North Garden
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Maxwell Beall

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Lemuel Beall
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 11 - 1851

8. AGE: Years	Months	Days	If less than one day
94	11 2	29 20	hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Alexandria Maxwell
13. Birthplace: Scotland
MOTHER 14. Maiden name: Elizabeth Hopkins
15. Birthplace: Maryland
16. Informant: Mrs Windsor Hodges
Address: Boyd, R.F.D. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/46 (month) (day) (year)
Cemetery or crematory: Monocacy
Location: Beallsville, Md
18. Funeral director: William B Hilton
Address: Barnesville, Md
19. Jan. 3 1946 (Date rec'd by registrar) Mrs. C. C. Hilton, Mrs. W. B. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 1946 at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1935 to Jan 14 1946 and that I last saw her alive on Jan 10 1946

	DURATION
Immediate cause of death: Cerebral Thrombosis	3 mo
Due to: Myocardial decompensation	10 da
Due to: General arterial failure	10 yrs
Due to: Senile decay	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Upton D Howe M.D. M. D. or other
Address: Dawsonville Md Date signed 1-2/46
P.O. Boyds.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of year of birth of deceased is shown on FILM No. I 0 4 MAY 31 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 2-18

1. PLACE OF DEATH:
County Montgomery
City or town Rural Etchison Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 9 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rural Etchison Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Hattie A Beall

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 ~~1855~~ 1854

8. AGE: Years	Months	Days	If less than one day
91	0	17	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business None
FATHER 12. Name William Miller
13. Birthplace Maryland
MOTHER 14. Maiden name Rebecca Watkins
15. Birthplace Maryland
16. Informant Walter Allnutt
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 26 1946 (month) (day) (year)
Cemetery or crematory Hyattstown Md
Location Montgomery Co Md
18. Funeral director Roy W. Barber
Address Laytonsville Md
19. 1/25/46 (Date rec'd by registrar) 19 46 L. D. Bell Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 23 1946, at 10:30 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1946, to Jan 23 1946, and that I last saw him alive on Jan 16 1946.

	DURATION
Immediate cause of death Myocardial degeneration	Unknown
Due to General debility from Senility	91 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Vernon H. Dyson M. D. or other
Address Laytonsville Md Date signed Jan 24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

00698

Reg. Dist. No. 714

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 636 Richey Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Louisa Beilstein

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Christian W. Beilstein
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec. 22, 1870

8. AGE: Years 75 | Months 0 | Days 13 | If less than one day ... hrs. ... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: Jacob Schaffer
13. Birthplace: Germany

MOTHER
14. Maiden name: Katherine Bayer
15. Birthplace: Germany

16. Informant: Frederick Beilstein
Address: 5621 Sherrier Pl., N.W.

17. Removal (Burial, cremation, or removal, Which?) Date thereof 1-6-46 (month) (day) (year)
Burial — Prospect Hill 1-8-46
Cemetery or crematory: 3072 M St. N.W.
Location: Washington D.C.

18. Funeral director: W. W. Chambers Co.
Address: 3072 M. St. N.W.

19. Jan 5 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5th 1946, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 14 1946 to Jan 5 1946
and that I last saw her alive on Dec. 2 1945

	DURATION
Immediate cause of death: Coronary thrombosis	2 hrs
Due to: Arteriosclerosis	15+ yrs
Due to: Essential hypertension	6+ yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? ...

23. SIGNATURE E. H. Aschenbach M. D. or other
Address 1007 L St. N.W. Date signed 1/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

00699

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:

County: Montg Co-

City or town: Germantown, (Rural) Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mo-

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montg

City or town: Germantown (Rural)

If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Nina Rebecca Berry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 25/1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
1867 78	7	6-		

9. Birthplace: Olney Md (Town, county, and state)

10. Usual occupation: Sales Lady-

11. Industry or business

FATHER 12. Name: Dorsey Berry

13. Birthplace: France

MOTHER 14. Maiden name: Angelina Griffith

15. Birthplace: France

16. Informant: Mrs Arnold Burdett

Address: Germantown Md-

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/2/46 (month) (day) (year)

Cemetery or crematory: Chestnut Grove Cemetery

Location: Herndon Va

18. Funeral director: Percel C Gaither

Address: Gaithersburg Md-

19. Jan 31 1946 (Date rec'd by registrar) Alsuda G Cook Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 1946 at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 Med. Exam 1946 to 1946

and that I last saw h alive on 1946

Immediate cause of death	DURATION
Acute Myocarditis	½ day
Due to: Chronic Myocarditis	6 mo
Due to: arteria sclerosis	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Bronkart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed 1-31-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01,709

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 22 Prospect St.
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Kensington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 22 Prospect St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Nannie Cora Bosse

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6(b) Name of husband or wife Louis Henry Bosse
6(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) March 20, 1869

8. AGE:

Years	Months	Days	If less than one day
76	9	14	— hrs. — min.

8. Birthplace Spartanburg, South Carolina (Town, county, and state)
10. Usual occupation housewife
11. Industry or business —

FATHER
12. Name James Bryant Kinnamt
13. Birthplace Fairfield County, S.C.

MOTHER
14. Maiden name Margaret Elizabeth Keltner
15. Birthplace Fairfield County, S.C.

18. Informant Mrs. B. P. Ramsby
Address 22 Prospect St., Kensington, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan 7th 1946 (month) (day) (year)
~~Cemetery or~~ crematory Fort Lincoln
Location Bladensburg Rd. - P.G. Co.
18. Funeral director Wood E. Pumphrey
Address Silver Spring, Md.

19. Jan 5 1946 (Date rec'd by registrar) Josephine W. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1946, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1944 to Jan. 4 1946 and that I last saw her alive on Dec. 17 1945

Immediate cause of death	DURATION
Myocarditis (chronic)	1½ yrs
Due to Bronchial asthma	20-30 years
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Katharine A. Chapman, M.D. M. D. or other
Address 20 West Baltimore St. Kensington, Md. Date signed 1/4/46

VS-A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-L

CERTIFICATE OF DEATH

011701

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County:
City or town: Paces
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II ✓

3.(a) FULL NAME: BOSWELL, David Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Lucy Boswell
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3-3-23

8. AGE: Years	Months	Days	If less than one day
22	10	11	hrs. min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: veteran
11. Industry or business

FATHER
12. Name: H. F. Boswell
13. Birthplace: Va.

MOTHER
14. Maiden name: Bessie Talbett
15. Birthplace: Va.

16. Informant: wife: Mrs. Lucy Boswell
Address: Paces, Virginia

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-18-46 (month) (day) (year)
Cemetery or crematory: Arbor Church Cemetery
Location: Danville, Va.
18. Funeral director: W. W. Chambers
Address: 1400 Chapin St., N. W., Wash., D.C.

19. 1-15 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 Jan 19 46, at 2:17 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Jan 19 46, to 15 Jan 19 46 and that I last saw h... im alive on 14 Jan 19 46

	DURATION
Immediate cause of death: Sarcoma, Lungs with massive pulmonary metastases	4 Mos
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible], Lt. Cdr. (MC) USN M. D. or other
Address: USNH Bethesda, Md. Date signed: 1-15-46

VS A15 1/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Diat. No. 06702 216

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: SOMERSET
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: MONTGOMERY

City or town: SOMERSET
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 513 SURREY ST. SOMERSET, CH. CH. MD.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: MARY MARGARET BRADY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6.(b) Name of husband or wife: JOHN B. BRADY

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): AUG. 23, 1850

8. AGE: Years: 95 | Months: 4 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: WASHINGTON, D.C.
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business: [redacted]

FATHER
12. Name: FREDERICK W. ECKLOFF

13. Birthplace: WASHINGTON, D.C.

MOTHER
14. Maiden name: MARGARET E. GODDARD

15. Birthplace: MARYLAND

16. Informant: MRS. MARGARET B. SHOEMAKER

Address: 4725 DRUMMOND AVE. CHEVY CHASE, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 1-16-46 (month) (day) (year)

Cemetery or crematory: MT OLIVET CEMETERY

Location: WASHINGTON, D.C.

18. Funeral director: Francis J. Collins

Address: 3821-14TH. ST. N.W. WASH. D.C.

19. 1/14/46 (Date rec'd by registrar)

Wm E. Jones
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JAN. 13 1946, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAR. 25 1945, to JAN. 13 1946 and that I last saw h[er] alive on JAN. 9 1946

Immediate cause of death	DURATION
CONGESTIVE HEART FAILURE	4 DAYS
Due to: CARDIO-VASCULAR RENAL DISEASE	6 YRS
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wilmer Chambers M.D.
M. D. or other

Address: 4921 Sangamon St. Date signed: 1/14/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

00763

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Eight (8) days

Hospital, Institution, or street address where death occurred: U. S. Naval Hospital, NNMC, Bethesda, Md.

How long in hospital or institution? Eight (8) days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Florida County: Dade

City or town: Miami (If outside city or town limits, write RURAL and give nearest town)

Street No. 835 Southwest 10th Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: CALAIS, William Yost

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-11-23

8. AGE: Years	Months	Days	If less than one day
22	1	20	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business:

FATHER — 12. Name: Arthur M. Calais; 13. Birthplace: South Carolina

MOTHER — 14. Maiden name: Elva M. Willets; 15. Birthplace: New Jersey

16. Informant: Arthur Moisson Calais, Brother

Address: 835 Southwest 10th Ave., Miami, Fla.

17. removal (Burial, cremation, or removal. Which?) Date thereof 1-3-45 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Miami, Florida

18. Funeral director: Geo. W. Wise J.C.F.

Address: 2900 M St., N. W., Wash., D.C.

19. 1-3-45 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 January 1946, at 9:26 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Dec 1945, to 3 Jan 1946 and that I last saw him alive on 12-26-45.

Immediate cause of death	DURATION
Respiratory paralysis	12 hrs.
Due to Concussion Brain Trauma	1 mo. ?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Intracranial Brain Trauma. Date of op. 1-2-46

Autopsy results: confirmed dx. fracture.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. B. Breeden Lt. (jg) MC M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-3-45

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(1/8/46)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

00704

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Days
Hospital, Institution, or street address where death occurred:
U. S. Naval Hospital Bethesda, Md.
How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County: Monts
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2711 Blane Dr. Rock Creek Forest,
Ch. Ch., Md. (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: CALNAN, John Leo VBP

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Irma Calnan
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 25, 1892

8. AGE: Years	Months	Days	If less than one day
54	0	6	hrs. min.

9. Birthplace: Massachusetts (Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business

FATHER
12. Name: John J. Calnan (dec)
13. Birthplace: Massachusetts

MOTHER
14. Maiden name: Josephine Cruden
15. Birthplace: Mass. (deceased)

16. Informant: Mrs. Irma Calnan
Address: 2711 Blane Dr., Rock Creek Forest, Chevy Chase, Md.

17. removal (Burial, cremation, or removal. Which?) Date thereof 1-31-46 (month) (day) (year)
Cemetery or crematory: St. Michaels
Location: Springfield, Mass.
18. Funeral director: W. E. Pumphreys
Address: 8434 Georgia Avenue, Silver Springs, Md.

19. 31 Jan 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 19 46, at 1020 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Jan 19 46, to 31 Jan 19 46 and that I last saw him alive on 31 Jan 19 46

Immediate cause of death	DURATION
Congestive Heart Failure	4 mo.
Due to Arterio Sclerotic Heart Disease	20 yrs.
Due to	
Other conditions Cirrosis of the liver	10 yrs.
Diabetes Mellitis	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: V. B. Ballard
V. B. BALLARD, Lt. (MC) USNR
M. D. or other
Address: U.S.N.H., Bethesda, Md. Date signed: 1-31-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

06705

CERTIFICATE OF DEATH

Reg. Dist. No. 24-6

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Suburban Hospital

How long in hospital or Institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 18 Forest Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mildred B. Campbell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
F	W	

6.(b) Name of husband or wife Frank L.

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1894.

8. AGE: Years 51 | Months 3 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace Pittsburgh Penna. (Town, county and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John S. Boyd

13. Birthplace Penn.

MOTHER 14. Maiden name Luella Scott

15. Birthplace Penn.

16. Informant Mr. F. L. Campbell

Address 18 Forest Ave. Rockville, Md

17. Shipment (Burial, cremation, or removal. Which?) Date thereof Jan. 27. (month) (day) (year)

Cemetery or crematory Pittsburgh, Pa.

Location Pa.

18. Funeral director Wm Reuben Plumphrey

Address Wisconsin Ave. Bethesda, Md

19. 1/27 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1946, at 11 40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1944, to Jan 25 1946

and that I last saw her alive on Jan 25 1946

	DURATION
Immediate cause of death Hypostatic pneumonia, Bronchial failure	1 wk
Due to Pulmonary carcinomatosis, metastatic	6 mo
Due to Mammary carcinoma.	18 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmatory of above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward Stuart M. D. or other

Address 1726 Eye St. N.W. Date signed Jan 25 '46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-a

CERTIFICATE OF DEATH

06706

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Derwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Moulgomery
City or town Derwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bessie Sarles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife John Hoaxe Sarles
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) February 22 - 1881

8. AGE: Years	Months	Days	If less than one day
64	11	7	hrs. min.

9. Birthplace Mt. Sulpper - Virginia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John Shuck
13. Birthplace Virginia

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Samuel E. Sarles (son)
Address Box 134 - Rockville - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 1 - 46 (month) (day) (year)
Cemetery or crematory Forest Oak -
Location Gaithersburg Moulg Co -
18. Funeral director Wm. Beulah Umpstead
Address Rockville - Maryland

19. 1/31/46 Josephine D. Hamilton
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 29 1946 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28 1946, to Jan. 29 1946
and that I last saw her alive on Jan. 28 1946

Immediate cause of death	DURATION
bronchio pneumonia	1 day to my knowledge
Due to Influenza - from history	2 or 3 Weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. O. Hartley M.D.
M. D. or other
Address Rockville Md Date signed 1/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00307

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution? 9½ hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Lincoln Park
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lewis R. Carter.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 12, 1901

8. AGE:

Years	Months	Days	If less than one day
44	5	20	..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: —

FATHER
12. Name: Bud Carter
13. Birthplace: —

MOTHER
14. Maiden name: Lilly
15. Birthplace: —

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4 1946 (month) (day) (year)

Cemetery or crematory: Lincoln Park

Location: Lincoln Park, Rockville, Md.

18. Funeral director: Robert L. Snowden

Address: Rockville, Maryland

19. 1-4-1946 (Date rec'd by registrar) Gertrude B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2 19 46, at 8:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Bronch-pneumonia	2 days.
Due to: Influenza	Unknown.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. M. D. or other

Address: Gaithersburg, Md. Date signed: 1-3-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8520

CERTIFICATE OF DEATH

00708

Reg. Dist. No. 229

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 HOURS

Hospital, Institution, or street address where death occurred:
WASHINGTON SANITARIUM

How long in hospital or institution? 20 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Mass. County: —

City or town: Boston
(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 Hudson Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WONG CHIN

3.(b) Social Security Number: 102-16-6862

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	CHINESE	SINGLE

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): OCT. 12, 1905

8. AGE: Years	Months	Days	If less than one day
40	2	23	____ hrs. ____ min.

9. Birthplace: San Francisco, Cal.
(Town, county, and state)

10. Usual occupation: WAITER

11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Wong W. Look
Address: 76 Beach St., Boston, Mass

17. Shipment + burial thereof: Jan. 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt. Hope Cemetery

Location: Boston, Massachusetts

18. Funeral director: Warner E. Dumphrey

Address: Silver Spring, Md.

19. Jan 8 1946
(Date rec'd by registrar)

[signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 5 1946, at 8.00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JANUARY 4 1946, to JANUARY 5 1946 and that I last saw h.i.m. alive on JANUARY 5 1946

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	
Due to: ARTERIAL HYPERTENSION	
MALIGNANT	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE

Date of op.: —

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: J. Marshall Terrill Jr. M.D.
M. D. or other

Address: 8712 Colesville Rd. Silver Spring, Md. Date signed: JAN. 5 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-e

CERTIFICATE OF DEATH

00769

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital Bethesda, Md.

How long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 East Gittings St. Baltimore, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Henry L. Alexander CIBOROWSKI, Lt.(jg) USNR

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Elizabeth Ciborowski

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10-10-23

8. AGE: Years	Months	Days	If less than one day
22	3	11	hrs. min.

9. Birthplace: Colo
(Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business:

FATHER
12. Name: STANLEY CIBOROWSKI
13. Birthplace: Poland

MOTHER
14. Maiden name: Spephany Wlodkowski
15. Birthplace: Poland

16. Informant: Mrs. Elizabeth Ciborowski
Address: 2 East Gittings St. Baltimore 35, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-23-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: George W. Wise J.C.J.

Address: 2900 M St. NW Washington, D.C.

19. Jan 27 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27 19 46, at 8:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Dec. 19 45, to 27 Jan 19 46

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Tumor, Mixed Malignant Testicle	8-12 mo.
Due to:	
Due to:	
Other conditions: Purulent Meningitis (Terminal)	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: Malignant Tumor of rt testicle. Date of op. 1945

Autopsy results: Metastases and Purulent Meningitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C.K. Copp C. T. KLOPP, Lt.(jg)(MC) USNR M. D. or other

Address: US NH Bethesda, Md. Date signed: 1-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 2/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-2)

CERTIFICATE OF DEATH

06719

Reg. Diat. No. 197

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Spencerville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jacqueline Ann Clemons.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 8, 1946

8. AGE:

Years	Months	Days	If less than one day
		7	hrs. min.

9. Birthplace Olney, Montgomery County, Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business —

FATHER
12. Name Thomas Clarence Clemons.
13. Birthplace Waurce, Florida.

MOTHER
14. Maiden name Eunice Maude Lantz
15. Birthplace Peru, West Virginia

16. Informant Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17, 1946 (month) (day) (year)

Cemetery or ~~crematory~~ Brethren

Location Rockland Maryland

18. Funeral director Roy M Barlup

Address Laytonsville Md.

19. Jan 16 1946 (Date rec'd by registrar) Gertrude S. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 19 46, at 6:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 19 46, to January 15 19 46 and that I last saw her alive on January 15 19 46

Immediate cause of death	DURATION
Congenital Heart disease	7 days.
Due to —	
Due to —	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations none Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm R. Linthicum M.D. M. D. or other

Address Rockville, Maryland Date signed 1/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06712

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years.

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Olney
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr. George Coleman.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 9, 1885

8. AGE: Years	Months	Days	If less than one day
61	0	8	hrs. min.

9. Birthplace Chestertown Maryland.
(Town, county, and state)

10. Usual occupation Hospital orderly

11. Industry or business —

FATHER
12. Name William H. Coleman
13. Birthplace Chestertown, Maryland.

MOTHER
14. Maiden name Anna Coleman.
15. Birthplace —

16. Informant Hospital record
Address

17. Burial Date thereof 1 17 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Damascus

Location Damascus, Maryland

18. Funeral director Ray M. Barker

Address Laytonsville, Md.

19. Jan 17 1946 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 17 1946 at 2:46 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1946, to January 17 1946 and that I last saw h.. alive on January 17 1946

Immediate cause of death	DURATION
Lobar pneumonia.	5 days.
Due to Chronic myocarditis	5 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas E Tunnicliff M. D.

Address Sandy Spring, Md. Date signed 1/17/46.

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00711

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

Reg. Dist. No. X14

1. PLACE OF DEATH:
County Montgomery
City or town Silver Springs Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9508 Biltmore Dr.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Lula Coburn

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	unmarried

6.(b) Name of husband or wife unknown
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 84 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace —
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name unknown
13. Birthplace
MOTHER 14. Maiden name unknown
15. Birthplace
16. Informant Lillie Mae Melton
Address 9508 Biltmore Dr.
17. removal Date thereof Jan 18 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Burial Rock Creek Jan. 19, 1946
Location Washington D.C.
18. Funeral director W. W. Chambers Co.
Address 1400 Chapin St. nw; Washington DC
19. Jan. 18 1946 Josephine K. Schaeffe
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1946, at 12:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to Jan 18 1946
and that I last saw h... alive on January 17 1946

Immediate cause of death	DURATION
Cardiac dilatation	1 day
Due to	
Due to	
Other conditions senile dementia	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. .....
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Wm A Shannon M.D.
M. D. or other
Address 1123 Connecticut Ave NW Date signed 1-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contrast is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06713

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:
U.S. NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2430 Wisconsin Ave. NW
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: BERT MICHEAL COMERFORD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: B.M. Comerford

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 17, 1876

8. AGE: Years	Months	Days	If less than one day
69	4	27	hrs. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: Veteran

11. Industry or business:

FATHER
12. Name: William Comerford
13. Birthplace: ?

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Wife, Mrs. B.M. Comerford
Address: 2430 Wisconsin, Ave NW Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: V.L. Speare Co. B Slye
Address: 1009 H St. NW Washington, D.C. Mary Charlotte Smith

19. Jan 15 19 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 Jan 1946 19..., at 1025 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Jan 19 46 to 14 Jan 19 46 and that I last saw him alive on 14 January 19 46

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to Coronary Heart Disease Arteriosclerotic	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Congestive heart failure, Coronary Arteriosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R.A. Conard Lt. Cdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 1-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 1/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

00714

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 805 Maple Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: District of Columbia
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 1910 Kalorama Rd. N. W. Ap. 501 (If rural, give LOCATION)
2.(a) If veteran, name war: none ✓

3.(a) FULL NAME: John S. Conway

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband or~~ wife: Eleanor M.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 16th. 1878

8. AGE: Years	Months	Days	If less than one day
67	4	5	... hrs. ... min.

9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Civil Engineer

FATHER
12. Name: John J. Conway
13. Birthplace: Phila. Pa.

MOTHER
14. Maiden name: Regina Rudolph
15. Birthplace: Phila. Pa.

16. Informant: Mrs. Eleanor M. Conway.
Address: 1910 Kalorama Rd. N.W. Wash. D.C.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 1/23/46 (month) (day) (year)
Cemetery ~~or crematory~~: Holy Cross
Location: Philadelphia, Pa.

18. Funeral director: Warner E Pumphrey
Address: 8434 Ga. Ave. Silver Spring. Md.

19. Jan 22 1946 (Date rec'd by registrar) J. Hilton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 21, 1946, at 1:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19, 1946, to Jan. 21 1946, and that I last saw him alive on Jan. 21, 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 h.
Due to: arterio-sclerosis	Indefinite
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? ...

23. SIGNATURE: J. B. Petty M.D. (M. D. or other)
Address: 6911 5th St. N.W. Wash. D.C. Date signed: 1/21/46

Evidence for addition of approximate age of deceased is shown on FILM No. 100 JAN 24 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

CERTIFICATE OF DEATH

00715

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred: USNaval Hospital, Bethesda, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W.Va. County:
City or town: Peidmont
(If ontside city or town limits, write RURAL and give nearest town)
Street No.:
(If rurnl, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: COOPER, Harry (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	C-US	married

6.(b) Name of husband or wife: Mrs. Edith Cooper
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Approx. 55			hrs. min.

9. Birthplace: Mo. (Town, county, and state)
10. Usual occupation: Veteran
11. Industry or business

FATHER
12. Name: ? Cooper
13. Birthplace: unknown

MOTHER
14. Maiden name: Maggie Cooper (Maiden unkn)
15. Birthplace: unknown

16. Informant: wife: Mrs. Edith Cooper
Address: Peidmont, W.Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof 1-11-46 (month) (day) (year)
Cemetery or crematory:
Location: Piedmont, W.Va.

18. Funeral director: W. Ernest Jarvis & Johnson & Mary Charlotte Smith
Address: 1432 U Street, N. W., Wash., D. C.

19. 1-10 19 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 Jan 19 46, at 12:25p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Jan 19 46, to 10 Jan 19 46
and that I last saw him alive on 10 Jan 19 46

Immediate cause of death:	DURATION
Subdural hematoma	
with Pontine hemorrhage	
left side	
Due to:	
Due to:	
Other conditions: Fracture Temporal bone right	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Subdural hematoma
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: undetermined
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. A. Conrad, Lt.Comdr.(MC) USN
M. D. or other
Address: US NH Bethesda, Md. Date signed: 10-10-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15
Rec'd by us
1-16-46

Evidence for change of year of birth of deceased is shown on

FILM No. I 0 1 MAR 13 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92a)

CERTIFICATE OF DEATH

66716

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mons, 12 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 mons, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5741 North Washington Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: COURTNEY, John Joseph, CMus(ret)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Alice Courtney

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2 July ~~1883~~ 1893

8. AGE:	Years	Months	Days	If less than one day
	52	6	15	hrs. min.

9. Birthplace: Ala
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Owen Ugene Courtney
13. Birthplace: Ireland (dec)

MOTHER
14. Maiden name: Dora Louise Wildberger
15. Birthplace: Ill. (dec)

16. Informant: wife: Mrs. Alice Courtney
Address: 5741 North Washington Blvd., Arl., Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-19-46 (month) (day) (year)

Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. Chambers & Bowen
Address: 3072 M. St., N. W., Wash., D. C.

19. 1-17 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 Jan 19 46, at 8:53 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5 Oct. 19 45, to 17 Jan 19 46
and that I last saw h im alive on 17 Jan 19 46

Immediate cause of death	DURATION
Coronary occlusion	1 wk.
Due to: Coronary Sclerosis	30 yrs.
Due to:	
Other conditions: Aortic Insufficency	
Marked hypertrophy of heart	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: V. B. Ballard for R. A. CONRAD, Lt.Cdr. (MC) USN
M. D. or other

Address: U.S.N.H., Bethesda, Md. Date signed: 1-17-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 00717 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days.

Hospital, Institution, or street address where death occurred:
Washington Sanitarium

How long in hospital or Institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland. County: Montgomery

City or town: Silver Springs Maryland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10216 Colesville Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nina Pessie Crumly

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married.

6.(b) Name of husband or wife: Glenn T. Crumly

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1898

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
47	2	9		

9. Birthplace: Fredonia (Town, county, and state) Kansas

10. Usual occupation: Secretary

11. Industry or business:

FATHER
12. Name: John Yohn
13. Birthplace: (not Known)

MOTHER
14. Maiden name: (Not Known)
15. Birthplace: (not Known)

16. Informant: husband.
Address: 10216 Colesville Rd. Silver Springs

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Jan. 9 1946 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: 3201 Bladensburg Rd. NE. Washington D.C.

18. Funeral director: Chas. H. Hyde Co

Address: 2901 14th St. N.W.

19. Jan 5 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 5 1946, at 7:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20 1945, to Jan. 5 1946

and that I last saw her alive on Jan. 2 1946

Immediate cause of death	DURATION
Cerebral hemorrhage Prob.	
from congenital aneurism of int.	16 days.
Due to carotid artery	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: injured at work?

23. SIGNATURE: W. H. McNeill, M.D. M. D. or other

Address: Silver Spring, Md. Date signed: 1/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00718

Reg. Diat. No. 217

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution? 11 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Duc.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mr. Ray Darby

3.(b) Social Security Number

4. Sex	5. Color or race	6.(d) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Mrs. Nettie Darby

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 30, 1888

8. AGE: Years	Months	Days	If less than one day
57	6	6	..... hrs. ..... min.

9. Birthplace: Woodyield, Maryland (Town, county, and state)

10. Usual occupation: Guard

11. Industry or business

FATHER

12. Name: Samuel T. Darby

13. Birthplace: Woodyield, Maryland.

MOTHER

14. Maiden name: Rosabelle Heiremin us

15. Birthplace: Martinsburg, West Va.

16. Informant: Hospital records.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/8/46 (month) (day) (year)

Cemetery or crematory: Forest Oak.

Location: Gaithersburg route

18. Funeral director: Edward C. Gaither

Address: Gaithersburg route

19. Jan 6 1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1946, at 2:10 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 26 1945, to January 6 1946 and that I last saw him alive on January 6 1946

	DURATION
Immediate cause of death: Coronary heart disease	11 days.
Due to: Pulmonary infarct	12 hours
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Sandy Spring, Md. Date signed 1-6-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

00719

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery County

City or town: Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 3/4 yrs.

Hospital, institution, or street address where death occurred:

Proctor Jolliffe Nursing Home

How long in hospital or institution? 2 3/4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 805 - Maple Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: LILLIAN JANE DAVIS

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Davis

6.(c) If alive, give age ... years (Dead)

7. Birth date of deceased (mo., day, yr.): October 4, 1863

8. AGE: Years: 82 | Months: 3 | Days: | If less than one day: ... hrs. ... min.

9. Birthplace: Norfolk, Virginia (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: —

FATHER — 12. Name: Richard Allen

13. Birthplace: Va.

MOTHER — 14. Maiden name: Susanna Knox

15. Birthplace: Va.

16. Informant: Mrs. A. W. Cummings

Address: 1954 - Col. Rd. N.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 2, 1946 (month) (day) (year)

Cemetery or crematory: Arlington Nat. Cem.

Location: Arlington, Virginia

18. Funeral director: Martin W. Hyslop Co.

Address: 1300 - N St. N.W.

19. Jan. 31 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31, 1946, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18, 1946, to Jan. 31, 1946, and that I last saw h... alive on Jan. 30, 1946.

	DURATION
Immediate cause of death: Congestive Heart failure	2 days
Due to: arterio - sclerosis	Indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: J. Steele Mills, M. D. or other

Address: 6911 5th St. N.W. Date signed: 1/31/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-6

00720

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Linwood Silver Spring Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years -

Hospital, institution, or street address where death occurred:
2308 Michigan Ave -

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Linwood Silver Spring Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2308 Michigan Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME

DeLOATCH, MILDRED (WILLIAMS)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widowed

6.(b) Name of husband or wife: Simon DeLoatch

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Not known. 1869

8. AGE: Years: 76 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: Orange Co. Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home.

FATHER
12. Name: Williams
13. Birthplace: Orange Co. Virginia

MOTHER
14. Maiden name: Margaret Parsons
15. Birthplace: Orange Co. Virginia

16. Informant: Charlotte Caffield

Address: 2308 Michigan Ave.

17. Removal — Date thereof: Jan. 2 2. 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Burial Pilgrim Baptist Jan 25, 1946
Cemetery or crematory

Location: Linwood, Silver Spring Md

18. Funeral director: Thomas Frazier

Address: 389 - R. I. Ave N. W.

19. Jan 22 1946 Josephine M. Schaaf
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22 1946 at 1.25 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 2 - 1945, to Jan 22 1946
and that I last saw h. alive on Jan. 20 1946

Immediate cause of death	DURATION
Myocarditis	1 year
Due to: Arteriosclerosis	15 years
Due to: Mitral regurgitation	10 yrs
Other conditions: Cerebral hemorrhage	11 yrs & 9 months

April 9, 1932
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. W. Mitchell M.D.
M. D. or other

Address: Silver Spring Md Date signed: 1-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-9)

CERTIFICATE OF DEATH

Reg. Dist. No. 0172 216

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
The Suburban

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 Exeter Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Wilkinson Fincher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed, or divorced~~
F	W	Married

6.(b) Name of husband or wife Charles F. Fincher

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 11, 1881

8. AGE: Years	Months	Days	If less than one day
64	5	2	..... hrs. ..... min.

9. Birthplace Georgia (Town, county, and state)

10. Usual occupation HW

11. Industry or business

FATHER 12. Name W. T. Wilkinson

13. Birthplace Georgia

MOTHER 14. Maiden name Sarah E. Russell

15. Birthplace Georgia

16. Informant Charles F. Fincher

Address 115 Exeter Rd., Bethesda, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1/13/46 (month) (day) (year)

Cemetery or crematory

Location LA GRANGE, GEORGIA

18. Funeral director Martin W. Hysong Co.

Address 1300 N St. N.W. Washington D.C.

19. 1/13 (Date rec'd by registrar) 1946 M E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1946, at 1:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1945, to Jan 13 1946, and that I last saw h[illegible] alive on Jan 13 1946

Immediate cause of death Cancer of Pancreas

DURATION

Due to

Due to

Other conditions Metastasis to Liver

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Cancer of the pancreas with

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Nowakowsky, M.D.
M. D. or other

Address Bethesda Md Date signed 1/13/46

STATE OF MARYLAND—CERTIFICATE OF DEATH

00722

1. PLACE OF DEATH (131-4)

County Montgomery — Registration Dist. No. 223-

Village or City Takoma Pk. Md. No. 6633 Eastern Ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. if of foreign birth? 63 yrs. ... mos. ... ds.

2. FULL NAME ADOLPH FLEISCHER If U.S. Veteran specify WAR ...

(a) Residence: No. 6633 Eastern Ave St., Ward. ...

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: ROSE Fleischer

6. DATE OF BIRTH (month, day, and year): June 17- 1867

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	6	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Confectionery Store owner -

10. Date deceased last worked at this occupation (month and year): July 1944

11. Total time (years) spent in this occupation: Life

12. BIRTHPLACE (city or town) (State or country): Budapest Hungary

FATHER

13. NAME: Joseph

14. BIRTHPLACE (city or town) (State or country): Budapest Hungary

MOTHER

15. MAIDEN NAME: Mary Gross

16. BIRTHPLACE (city or town) (State or country): Budapest Hungary

17. INFORMANT: Mrs Sarah Gottesd Sister

(Address) 6633 Eastern Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Hebrew Jewish Cemetery Date Jan 9, 1946

19. UNDERTAKER Levinson Memorial Chapel

(Address) 4717-9th St. NW

20. FILED 3/4, 1946 J. William Doll

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Jan (Month) 8 (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1946, to Jan 8, 1946

I last saw him alive on Jan 7, 1946; death is said to have occurred on the date stated above, at 2 P.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importence were as follows:

	Date of onset
Chr. nephritis	?

Other Contributory Causes of importance:

generalized arteriosclerosis

paralysis agitans

Name of operation ... Date of ...

What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of Injury ...

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ...

(Signed) E. W. Markwood M. D.

(Address) 3208-9th St. N.W. Wash. D.C.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-E)

CERTIFICATE OF DEATH

00723

Reg. Dist. No. 2216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 da.

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 25 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1147 Parkwood Place, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME French, Walter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Ida French

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 16, 1880

8. AGE: Years 65 | Months 0 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace Hamilton N. J. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name John T. French

13. Birthplace N. J.

MOTHER 14. Maiden name Virginia Alexander

15. Birthplace Virginia

16. Informant Hospital Records

Address Suburban Hospital, Bethesda, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1946 (month) (day) (year)

Cemetery or crematory Cremation

Location .....

18. Funeral director J. William Lee & Sons

Address 300-7th N.E.

19. 1-13-46 19..... W. S. Jobes Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 19 46, at 11 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18 19 45 to Jan 12 19 46

and that I last saw h. alive on Jan 12 19 46

	DURATION
Immediate cause of death Hepatitis a. Pneumonia.	6 days.
Due to Pyloric obstruction complete.	6 wks.+
secondary duodenal ulcer.	
Due to Undernutrition.	2 yrs.
Other conditions Supervening intestinal obstruction following gastroenterostomy (Include pregnancy within 3 months of death)	3 wks

Major findings of operations Scarred occlusion duodenal orifice stomach Date of op. 12/26/45

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Edward H. Angle M.D. M. D. or other

Address 172 E. Eye Str. N.W. Date signed 1/13/46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 64-C

00724

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Dickerson (If outside city or town limits, write RURAL and give nearest town) R.F.D.
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred: Derwood R.F.D.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Derwood (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Raymond A. Friend

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 2 1902

8. AGE:

Years	Months	Days	If less than one day
43	3	10	hrs. min.

9. Birthplace: Garrett Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Oscar Friend
13. Birthplace: md

MOTHER
14. Maiden name: Mary Rodeheaver
15. Birthplace: md

16. Informant: Mary Brooks
Address: Derwood md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 14 1946 (month) (day) (year)
Cemetery or crematory: Friends
Location: Sandy Spring md
18. Funeral director: Roy W Barber
Address: Laytonsville md

19. Jan 14 1946 (Date rec'd by registrar) Gertrude B. Lawlor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 12 1946, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 Med. Exam 1946, to 1946
and that I last saw h alive on 1946

Immediate cause of death	DURATION
Hemorrhage.	Few minutes
Due to Bullet wound Thru skull	instantly
Due to (Secondary)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 1-12-46
Where did injury occur? Derwood (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: bullet wound Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D.
Dep. Med Exam. M. D. or other
Address: Gaithersburg md Date signed 1-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change in age is shown on FILM NO. 104 MAY 28 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06725

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Garrett Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs —
Hospital, Institution, or street address where death occurred:
12 Montrose St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg.
City or town Garrett Park,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Montrose St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Bertus D. Gamble

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife Rhoda

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1880

8. AGE: Years 65 6/6 | Months 3 | Days | If less than one day ... hrs. ... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual occupation Clerk, Tax Court of U.S.

11. Industry or business

FATHER
12. Name Hezikiah Gamble
13. Birthplace Pa.

MOTHER
14. Maiden name Emma Hair.
15. Birthplace Pa.

16. Informant Mrs. Rhoda Gamble
Address Garrett Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/2/46 (month) (day) (year)

Cemetery or crematory Forest Lawn Cem.
Location Maryland

18. Funeral director Wm Ledden Humphrey
Address Bethesda, Maryland

19. 2/2 1946 (Date rec'd by registrar) Wm E Forbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1946 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 30 1946 to Jan 30 1946 and that I last saw him alive on Jan 30 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	12 hrs.
Due to Arteria Sclerosis	4 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Bradley D. Hodgkins MD
M. D. or other
Address 313 W. Bradley Lane Date signed 1-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134a)

CERTIFICATE OF DEATH

00726

★ Reg. Diat. No. 716

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Chevy Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. # 5 - Dewlands ST
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME EMMA G HAGER | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife WILLIS D. HAGER
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JANUARY 5, 1854

8. AGE: Years 92 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace ELIZABETH, N. J. (Town, county, and state)
10. Usual occupation NONE
11. Industry or business

FATHER
12. Name THOMAS GILBERT
13. Birthplace N. J.

MOTHER
14. Maiden name PHOEBE MATTHEWS
15. Birthplace N. J.

16. Informant MRS. LOUISE C. HOEHLING
Address 15 Nevada St. CH. CH. MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 1-22-46 (month) (day) (year)
Cemetery or crematory Oak Hill
Location Washington D.C.
18. Funeral director Jos. Gawler's Sons
Address 1756 - Pa. Ave. N.W.
19. 1-20 1946 Wm E Jolley (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1946 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 3, 1946, to Jan. 19, 1946
and that I last saw h-er alive on Jan. 19, 1946

	DURATION
Immediate cause of death Congestive Heart Failure	24 hrs
Due to Cardio-vascular-renal disease	5 yrs
Due to	
Other conditions Thrombo-phlebitis left popliteal	3 days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Sidney Labovitz M.D.
M. D. or other
Address 3921 Livingston St. Date signed 1/19/46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8-17 PD
Geo.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06727

Reg. Dist. No. 216

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 months

Hospital, Institution, or street address where death occurred: 11 Woodhaven Blvd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Woodhaven Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Leah Young Hagerman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife: William E.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 17, 1870

8. AGE:

Years	Months	Days	If less than one day
75	4	14	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: George Holmes

13. Birthplace: England

MOTHER

14. Maiden name: Mary Ellen Hall

15. Birthplace: England

16. Informant: Caroline E. Dean

Address: 11 Woodbine Blvd. Bethesda

17. Shipment (Burial, cremation, or removal. Which?) Date thereof Feb. 3, 1946 (month) (day) (year)

Cemetery or crematory: Indian Hill Cemetery

Location: Middletown, Conn.

18. Funeral director: Wm Reuben Pumphrey

Address: Bethesda, Maryland

19. 2/3 1946 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 31, 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1946, to Jan 31 1946 and that I last saw h.e.r. alive on Jan 31, 1946

Immediate cause of death	DURATION
Acute Heart Failure	
Due to Arteriosclerosis + hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Frank Jaggers M.D. M. D. or other

Address ..... Date signed .....

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

CERTIFICATE OF DEATH

00728

Reg. Diat. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Rural Woodfield Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rural Woodfield Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Arthur C Haney

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Justine May Haney
6.(c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) Dec 3 1873

8. AGE: Years	Months	Days	If less than one day
72	1	24	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business Farming

FATHER
12. Name John Haney
13. Birthplace Md

MOTHER
14. Maiden name Harriett Ward
15. Birthplace Md

16. Informant Mrs. Justine May Haney
Address Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 29 1946 (month) (day) (year)
Cemetery or crematory Laytonsville Md
Location Montgomery Co Md
18. Funeral director Roy W. Barber
Address Laytonsville Md
19. 1/29 1946 R. D. Bell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 1946, at 2 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1946, to Jan 27 1946
and that I last saw h alive on Jan 25 1946
Immediate cause of death Uraemia — DURATION Two Wks
Due to acute Nephritis — Unknown
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Vernon H Ryan, M D
M. D. or other
Address Laytonsville Md Date signed Jan 28 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00729

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3713 4th Street, S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HANSEN, Kitty Frantzen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1882

8. AGE: Years	Months	Days	If less than one day
63	11	21	hrs. min.

9. Birthplace: Denmark
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Adolph Frantzen

13. Birthplace: Denmark

MOTHER — 14. Maiden name: unknown

15. Birthplace: Denmark

16. Informant: son: Ch.Pho. Peter A Hansen

Address: 3713 4th St. S.E.

17. cremation (Burial, cremation, or removal. Which?) Date thereof: 1-11-46 (month) (day) (year)

Cemetery or crematory:

Location:

18. Funeral director: Lee Funeral Home W. T. Sullivan

Address: 4th & Mass., Ave., N.E., Wash., D.C.

19. 1-10 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 Jan 19 46 at 3:23 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Jan 19 46, to 10 Jan 19 46 and that I last saw her alive on 10 Jan 19 46

Immediate cause of death	DURATION
Thrombosis, coronary	1 mo
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Thrombosis, coronary & arteriosclerosis Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. S. Barnes M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-0-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 1-16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

00730

Reg. Dist. No. 2/3-

1. PLACE OF DEATH:
County Moulgomery
City or town Potomac - Rural rw Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
R F D Rockville - Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Moulgomery
City or town Potomac - Rural rw Potomac
(If outside city or town limits, write RURAL and give nearest town)
Street No. R - F. D - Rockville - Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Marilla Harris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Joseph M. Harris
6.(c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) October 11 - 1878

8. AGE: Years	Months	Days	If less than one day
67	3	13	...hrs. ...min.

9. Birthplace Potomac - Moulg. Co - Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Frank R. W. Collins
13. Birthplace Louisville - Virginia

MOTHER
14. Maiden name Harriett Hunter
15. Birthplace Moulg. Co - Maryland

16. Informant Joseph R. Harris - (Son)
Address R-F.D. Rockville - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 27/46 (month) (day) (year)
Cemetery or crematory Methodist Church
Location Potomac - Maryland
18. Funeral director Wm. Reuben Pumphrey
Address Rockville - Maryland

19. 1/24/46 (Date rec'd by registrar) Josephine D. Hartle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 24 1946 at 9.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 16 1946, to Jan. 24 1946 and that I last saw h.. alive on Jan. 16 1946

Immediate cause of death	DURATION
Coronary thrombosis	8 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

23. SIGNATURE G. V. Hartle, M. D. M. D. or other
Address Rockville, Md Date signed 1/25/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8-5a)

00731

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Olney

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Claudine Harriss

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Mr. Eugene Harriss

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 17, 1879

8. AGE: Years 66 | Months 5 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Olney, Montgomery County, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home.

FATHER 12. Name George Cashell

13. Birthplace Montgomery County, Maryland

MOTHER 14. Maiden name Mary Elizabeth Barnsley

15. Birthplace Montgomery County, Maryland

16. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28 1946 (month) (day) (year)

Cemetery or crematory St. Louis Olney Md

Location Montgomery Co Md

18. Funeral director Roy W. Barber

Address Laytonsville Md

19. Jan 28 1946 (Date rec'd by registrar) Gertrude B. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/26/ 1946, at 11:55 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/16/ 1946, to 1/26/ 1946

and that I last saw him alive on 1/20/ 1946

Immediate cause of death	DURATION
a Cerebral Hemorrhage	10 days
Due to Arterio Sclerosis	8 "
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE [signature] M.D. M. D. or other

Address Sandy Spring Md Date signed 1/26/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3rd)

CERTIFICATE OF DEATH

★ 60732 Reg. Dist. No. 2-14

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS-A15

7

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital, Institution, or~~ street address where death occurred:
509 Ritchie Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 509 Ritchie Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Ross John Haugh

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband or~~ wife: Emma

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 26th. 1871

8. AGE: Years	Months	Days	If less than one day
74	11	23	____ hrs. ____ min.

9. Birthplace: Brookeville, Pa.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farming

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Emma Haugh

Address: 509 Ritchie Ave. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/22/46 (month) (day) (year)

Cemetery or crematory: St. Mary's

Location: Rockville, Md.

18. Funeral director: Warner E Pumphrey

Address: 8434 Ga. Ave. Silver Spring, Md.

19. Jan 21 1946 Josephine M Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 19 1946 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 14 1945 to Jan. 18 1946 and that I last saw h.. alive on Jan. 18 1946

Immediate cause of death	DURATION
Acute myocardial insufficiency	1 day.
Due to: Arteriosclerotic changes.	1½ yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work? ____

23. SIGNATURE: W. F. McNeill M.D.
M. D. or other

Address: Silver Spring, Md. Date signed: 1/20/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00733

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 days

Hospital, Institution, or street address where death occurred:
Suburban Hosp, Bethesda Md.,

How long in hospital or institution? 55 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Rockville R.R. #2
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. #2
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Barbara Haven

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, ~~married, widowed, or divorced~~
F	W	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1945

8. AGE: Years	Months	Days	If less than one day
9months	9	14	hrs. min.

9. Birthplace Rockville, Maryland
(Town, county, and state)

10. Usual occupation —— 0

11. Industry or business —— 0

FATHER
12. Name Ellis Haven
13. Birthplace Virginia

MOTHER
14. Maiden name Elsie Mussel
15. Birthplace Virginia

16. Informant MR ELLIS HAVEN.

Address ROCKVILLE. RT. #2.

17. Removal o Burial (Burial, cremation, or removal. Which?) Date thereof Jan - 31 - 1946 (month) (day) (year)

Cemetery ~~or crematory~~ KEMBERLIN

Location RURAL RETREAT. - WYTHE Co. - VA.

18. Funeral director James E Pumphrey

Address 8134 Ga Ave Silver Spring - Md.

19. 1-31-46 19 (Date rec'd by registrar) W S Gibbes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1946, at 12 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/6 1945, to 1/30 1946

and that I last saw h... alive on 1/30/ 1946

Immediate cause of death	bronchopneumonia.	DURATION
Due to	malnutrition & vitamin A deficiency;	
Due to	pancreatic dysfunction	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. S.T. Kimball, Jr., M.D. or other

Address Bethesda Suburban Hosp. Date signed 1/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

8012

Etown Road

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15—1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1867)

CERTIFICATE OF DEATH

06734

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, ~~Institution, or street address~~ where death occurred:
Suburban Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 836 Bonifant Street
(If rural give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas Clinton Hawkins

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband or~~ wife Annie Gertrude
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 11, 1869

8. AGE: Years	Months	Days	If less than one day
76	11	16	..... hrs. ..... min.

9. Birthplace Clarksburg Md.
(Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business
FATHER 12. Name John T. Hawkins
13. Birthplace Md.
MOTHER 14. Maiden name Annie E. Thompson
15. Birthplace Md.
16. Informant Mrs. Mary H. Fike
Address 836 Bonifant St, Silver Spring Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 29, 1946 (month) (day) (year)
Cemetery ~~or crematory~~ Monocacy Cemetery
Location Barnesville, Md.
18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.
19. Jan. 29 1946 (Date rec'd by registrar) Josephine McSchaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 27 1946, at 2:55 P.M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Traumatic meningitis	2 days
Due to Fracture of skull (accidental)	9 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

C. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accidental Date of 1-17-46
Where did injury occur? Silver Spring (City or town) Montg. (County) Md. (State)
Injured at home, farm, industry, public place (where?) home
Means of injury fall Injured at work? no

23. SIGNATURE Frank J. Broschart M.D.
Dep. Med. Exam. M. D. or other
Address Gaithersburg Md. Date signed 1-28-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

06735

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred:

9717 Sutherland Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9717 Sutherland Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Howard S. Haygthe

3.(b) Social Security Number: 577-07-4744

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Sarah E. Haygthe

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.): Apr 4 1885

8. AGE:

Years	Months	Days	If less than one day
60	8	14	...hrs. ...min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Office manager

11. Industry or business: transportation

FATHER — 12. Name: John B.R. Haygthe

FATHER — 13. Birthplace: maryland

MOTHER — 14. Maiden name: Rebecca Dailey

MOTHER — 15. Birthplace: Maryland

16. Informant: Wm H Haygthe

Address: 5403 5th St N.W. DC.

17. (Burial, cremation, or removal. Which?) Buried Date thereof (month) (day) (year) Jan 9 1946

Cemetery or crematory: Congressional

Location: Washington, D.C.

18. Funeral director: Wm J. Malley

Address: 522 - 8th st SE. Wash. D.C.

19. Jan. 6 1946 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 19 46 at 12:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 1 med Exam - case 19 to 19

and that I last saw h... alive on 19

Immediate cause of death	DURATION
Coronary occlusion	Instant suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank J. Bronchart M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg md Date signed 1-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

00736

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

00736

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:
Bethesda Suburban Hospital.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Poolesville,
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henrietta Ann Hebron

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, ~~widowed, or divorced~~
F	C	M

6.(b) Name of husband ~~or wife~~ James Edward Hebron

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) June 13, 1888

8. AGE: Years	Months	Days	If less than one day
57	6	24	..... hrs. ..... min.

9. Birthplace Poolesville, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business "

FATHER 12. Name Philip Johnson

13. Birthplace Poolesville, Maryland

MOTHER 14. Maiden name Rachel Ann Beander

15. Birthplace Poolesville, Maryland

16. Informant Hospital Record.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 10, 1945 (month) (day) (year)

Cemetery or crematory Sugarland Cem

Location Sugarland, Md.

18. Funeral director C. H. Ramsey

Address Poolesville, Md.

19. 1/10 1946 Wm E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/7 1946 at 4:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/30 1945 to 1/7 1946 and that I last saw h. alive on 1/2/46 19..

	DURATION
Immediate cause of death Stroke - Cerebral Hemorrhage	8 days
Due to generalized arteriosclerosis and hypertension	5 yrs.
Due to	
Other conditions diabetes	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. S. T. Kimble, Jr. M. D. or other

Address Bethesda Suburban Hosp. Date signed 1/7/46.

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

06737

Reg. Dist. No. 2-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 Lexington Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Luther Calvin Holmes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	white	married

6.(b) Name of husband or wife: L Flora Holmes

6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.): Sept 7, 1870

8. AGE:

Years	Months	Days	If less than one day
75			..... hrs. ..... min.

9. Birthplace: N. Y. (Town, county, and state)

10. Usual occupation: Engineer (Retired)

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: N. Y.

MOTHER

14. Maiden name: Adelaide Spencer

15. Birthplace: N. Y.

16. Informant: George W. Shakelton

Address: 401 Lexington Drive

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 19 1946 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Washington D.C.

19. Funeral director: Deal Funeral Home

Address: 4812 Ga. Ave. N.W.

19. Jan. 17, 1946 (Date rec'd by registrar) A.W. Hedrick Registrar B

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 1946 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to January 16 1946

and that I last saw him alive on January 16 1946

	DURATION
Immediate cause of death: Bronchopneumonia	2 days
Due to: Hypertension,	several years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Andrews M.D. M. D. or other

Address: Silver Spring Md Date signed: 1-16-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

06738

CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:
Suburban Hosp Bethesda maryland

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Monty

City or town Crest View
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4906 Bayard Blvd.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Julia W. Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband ~~or wife~~ August B. Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	9	..... hrs. ..... min.

9. Birthplace ? Sweden
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace ? Sweden

MOTHER
14. Maiden name ?
15. Birthplace ? Sweden

16. Informant Hospitals Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof 1-22-46 (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director W. W. Chambers Co

Address 1400-Chapin ST. N.W. Wash. D.C.

19. 1/22 (Date rec'd by registrar) 19 46 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22-'46 19..... at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-15-46 19..... to 1-22-46 19.....

and that I last saw h... alive on 1-22-46 19.....

Immediate cause of death	DURATION
Stroke	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Arteriosclerosis

Date of op.

Autopsy results Heart not opened Degenerated myocardium

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE S. Nowakowsky M. D. or other

Address Suburban Hosp. Bethesda Md Date signed 1-22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 415 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00739

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH: Montg Co,
County
Redland Md,
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Mo
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montg
City or town Redland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Howard Kelley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 1st 1945

8. AGE: Years	Months	Days	If less than one day
1945	8 Mos		hrs. min.

9. Birthplace Redland Md,
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Deen Kelley
13. Birthplace Va,

MOTHER
14. Maiden name Janace S Griffin
15. Birthplace Va,

16. Informant Deen Kelley
Address Redland. Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/46 (month) (day) (year)
Cemetery or crematory Brethern Church Cemetery
Location Redland. Md,
18. Funeral director Ernest C Gartner
Address Gaithersburg. Md,

19. Jan 2 1946 (Date rec'd by registrar) Abuda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1st 1946 19 at 2.20Am M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 19 45 to Dec 31 19 45
and that I last saw h... it alive on Dec 31 19 45

Immediate cause of death	OURATION
Bronchopneumonia	
Due to	
cold	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Gaithersburg Md Date signed Jan 1, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-a)

CERTIFICATE OF DEATH

00740

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 days

Hospital, Institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4624 S. Chelsea Lane
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Thomas Francis Kenny

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Kate Daley Kenny (Dec)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1853

8. AGE: Years	Months	Days	If less than one day
92	1	3	..... hrs. ..... min.

9. Birthplace Meulburg W. Va.
(Town, county, and state)

10. Usual occupation Insurance Agent

11. Industry or business Mutual + Home Ins. Co

FATHER 12. Name Thomas Kenny

13. Birthplace Ireland

MOTHER 14. Maiden name Mary O Connor

15. Birthplace Ireland

16. Informant Mrs. Wm. M. Miller

Address 4624 Chelsea Lane Chevy Chase

17. Shipment (Burial, cremation, or removal, which?) Date thereof 1/31/46 (month) (day) (year)

Cemetery or crematory St. Peter's Catholic Cem-

Location Piedmont, West Va.

18. Funeral director Wm Reuben Cumphrey

Address Bethesda, Maryland

19. 1/31 1946 Wm E. Deo Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-29 1946 at 3 00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1937 to January 29 1946

and that I last saw him alive on January 28 1946

Immediate cause of death	DURATION
Pyonephrosis	2 weeks
Due to Pyelocystitis	1 years
Due to Prostatic hypertrophy	12 years
Other conditions Senility	
Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations Prostatectomy - cystostomy

Date of op. 8 Jan 1946

Autopsy results Pyonephrosis, pyoureter, right, purulent cystitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Brent T. Benjamin M.D.
M. D. or other

Address Bethesda, Maryland Date signed 1/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-A)

CERTIFICATE OF DEATH

00741

216

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: P. Geo.

City or town: Chillum
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1206 Chillum Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: KERN, Irving Girard

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male (MALE)	W-US	married

6.(b) Name of husband or wife: Mrs. Hazel Kern

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 12, 1899

8. AGE: Years	Months	Days	If less than one day
46	1	28	..... hrs. ..... min.

9. Birthplace: N.J.
(Town, county, and state)

10. Usual occupation: veteran

11. Industry or business:

FATHER
12. Name: John Kern
13. Birthplace: N.J.

MOTHER
14. Maiden name: Rosa Schoonoer
15. Birthplace: N.J.

18. Informant: wife: Mrs. Hazel Kern
Address: 1206 Chillum Road, Hyattsville, Md. Chillum,

17. burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 17, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers

Address: 1400 Chapin St., N. W., Wash. D.C.

19. 1-14 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 Jan 19 46 at 10:06P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10 Jan 19 46 to 13 Jan 19 46 and that I last saw him alive on 13 Jan 19 46

Immediate cause of death	DURATION
Congestive Heart failure	
Due to: Hypertensive heart disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Congestive heart failure, Nephrosclerosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

SIGNATURE: R. A. Conard, Lt Cdr (MC) USN
R. A. CONARD, Lt. Cdr. (MC) USN
M. D. or other

Address: US NH Bethesda, Md. Date signed: 1-14-46

VS A15 (1/19/46)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

00742

Reg. Diat. No. 216

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two hours 20 min.

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 hours, 20 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Va. County:

City or town: Dahlgren

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3024 3rd Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: KIPFER, Eilene Elizabeth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

B.(b) Name of husband or wife: Vincent Joseph Kipfer, GMlc

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-28-21

8. AGE:

Years	Months	Days	If less than one day
24	4	25	hrs. min.

9. Birthplace: Michigan (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER

12. Name: [illegible] Funke (deceased)

13. Birthplace: unknown

MOTHER

14. Maiden name: Ritter

15. Birthplace: unknown

16. Informant: husband: Vincent J. Kipfer

Address: 3024 3rd St., Dahlgren, Va.

17. removal (Burial, cremation, or removal. Which?) Date thereof 1-23-46 (month) (day) (year)

Cemetery or crematory:

Location: Flint, Michigan

18. Funeral director: W. W. Chambers K. Langston

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 1-23 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 January 1946, at 3:20 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Jan 1946, to 23 Jan 1946 and that I last saw her alive on 23 Jan 1946

	DURATION
Immediate cause of death: Cerebro-vascular accident	24 hours
Due to:	
Due to:	
Other conditions: Pneumonia, lobar	10 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Thrombosis arterial, cerebral

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: T. S. BARNES, Lt. Cdr. (MC) USN M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 1-23-46

Item 14: Second Certificate filmed 9-20-46 G107-u

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95c)

06743

CERTIFICATE OF DEATH

Reg. Dist. No. 223

M

Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

MARGIN RESERVED FOR BINDING

VS A15

I

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs 19 Days
Hospital, institution, or street address where death occurred: 45 Poplar Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Montgomery
City or town: Takoma Park (If outside city or town limits, write RURAL and give nearest town)
Street No. 228 Cedar Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARTHA J. KYLE
3.(b) Social Security Number

4. Sex: F
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: SINGLE
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): DEC 5, 1862
8. AGE: Years 83 Months 1 Days 18 If less than one day ... hrs. ... min.
9. Birthplace: CEDARVILLE Ohio (Town, county, and state)
10. Usual occupation: Teacher
11. Industry or business: Univ of Illinois
FATHER 12. Name: Thomas B Kyle
13. Birthplace
MOTHER 14. Maiden name: Margaret ~~[illegible]~~ J. Henderson
15. Birthplace
16. Informant: Hospital Records
Address: 45 Poplar Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 26, 1946 (month) (day) (year)
Cemetery or crematory: Mt Hope Cemetery
Location: Urbana, Illinois
18. Funeral director: [illegible]
Address: [illegible]
19. Jan 23 1946 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 23 1946, at 9:17 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOVEMBER 4 1946, to January 23 1946; and that I last saw her alive on January 21 1946.

	DURATION
Immediate cause of death: Cardiac dilatation	Sudden
Due to: Arteriosclerosis	Several years
Due to:	
Other conditions: Old age	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Wm A. Shannon M. D. (M. D. or other)
Address: 123 Carroll St NW Date signed: Jan 23, 1946

Evidence for change of age is shown on FILM No. I 00 JAN 24 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

00744

Reg. Dist. No. 216

1. PLACE OF DEATH.
County Monts.
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: 4505 Windsor La.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residecce of mother)
State Maryland County Montg.
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest towo)
Street No. 4505 Windsor Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John M. ter Linden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married.

6.(b) Name of husband or wife Mary D.
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) March 5, 1870

8. AGE: Years	Months	Days	If less than one day
75 - 76			....hrs. ....min.

9. Birthplace Holland (Towo, couoty, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name Anton ter Linden
13. Birthplace Holland

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Mary D. ter L
Address 4505 Windsor La.

17. Burial Date thereof 1 | 18 | 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rockville Union Cem-
Location Rockville, Maryland
18. Funeral director Wm Reuben Pugh Chevy
Address Bethesda, Maryland

19. 4/16/46 Wm E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1946 at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 7. 1946, to Jan. 15 1946
and that I last saw him alive on Jan. 13 1946
Immediate cause of death Coronary Thrombosis — DURATION 1 week

Due to
Due to
Other conditions
(Include pregnancy within 3 mooths of death)

Major fiudings of operations
Date of op.
Autopsy results
PHYSICIAN: Plesse underline the cause to which death should be charged statistics By.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. V. Hartley M. D.
M. D. or other
Address Rockville, Md. Date signed 1/15/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (188)

CERTIFICATE OF DEATH

01745

Reg. Diat. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Montgomery County Emirad Hosp
How long in hospital or institution? Dec 6 to Jan 7-1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery Co Md
City or town Sandy Spring Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Gilbert S. Matthews

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife Minnie M. Matthews
6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) March 1 - 1891

8. AGE: Years 54 | Months 9 | Days 7 | If less than one day ... hrs. ... min.

9. Birthplace Sandy Spring Md (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Farm
FATHER 12. Name Walter Matthews
13. Birthplace Sandy Spring Md
MOTHER 14. Maiden name Lucy Powell Matthews
15. Birthplace Sandy Spring
16. Informant Lucy Matthews
Address Sandy Spring Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 11-1946 (month) (day) (year)
Cemetery or crematory Sandy Spring Md
Location Montgomery Md
18. Funeral director Roy W. Barber
Address Laytonsville Md
19. Jan 9 1946 (Date rec'd by registrar) Gertrude B. Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 19 46, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 med. Exam 19 , to 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death Cerebral shock	1 day
Pulmonary edema with hemorrhage	1 day
Due to Fall from house causing	
Due to fracture of skull	
(accidental)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 1-6-46
Where did injury occur? Sandy Spring (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?) highway
Means of injury Fall from house Injured at work? No

23. SIGNATURE Frank J. Bronstrup M.D. M. D. or other
Address Gaithersburg Md Date signed 1-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for addition of age of deceased is shown on FILM No. I 00 FEB 1 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01746

Reg. Dist. No. 212

1. PLACE OF DEATH: County Fluvanna Poolesville R.F.D. #1
City or town Poolesville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County Hanover
City or town Beaver Dam (Mr. Richmond)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Stuart McClung

3.(b) Social Security Number 225-20-0044

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hazel Marie Rolfe
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 30 1906

8. AGE: Years 39 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Greenbrier Co. W. Va.
(Town, county, and state)
10. Usual occupation Beautician
11. Industry or business Hair dressing

FATHER
12. Name Spencer H. McClung
13. Birthplace W. Va.

MOTHER
14. Maiden name Mary Dougher
15. Birthplace W. Va.

16. Informant Hazel M. McClung
Address R.F.D. #1 - Poolesville Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 19, 1946. (month) (day) (year)
Cemetery or crematory Mt Calvary
Location Redemption Plot
18. Funeral director Asphalt Paving Co
Address Richmond Va

19. Jan 15 1946 (Date rec'd by registrar) Charles E. Elgin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1946 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943 to Jan 15 1946
and that I last saw h... alive on Jan 15 1946

	DURATION
Immediate cause of death Carcinoma of the lung	6 mo
Due to Primary Carcinoma of the left kidney with metastases	2 1/2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of left kidney with nephrectomy Date of op. June 1944
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Upton D Monroe M.D
M. D. or other
Address Doswellville Va Date signed 1-16-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of usual occupation of deceased is shown on

FILM No. I 00 FEB 11 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-2

CERTIFICATE OF DEATH

00747

Reg. Dist. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr
Hospital, Institution, or street address where death occurred:
Monty. Co. Gen. Hosp
How long in hospital or institution? 1 hr

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville R.F.D. #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Willie Smith McGaha

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Annie
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Mar. 11, 1891

8. AGE:

Years	Months	Days	If less than one day
54	9	25	hrs. min.

9. Birthplace: Rockville, Md.
(Town, county, and state)
10. Usual occupation: Housewife Guard
11. Industry or business: U.S. Government

FATHER
12. Name: Thomas C. McGaha
13. Birthplace: Va

MOTHER
14. Maiden name: Martha L. Smith
15. Birthplace: Maryland

18. Informant: Howard D. McGaha
Address: Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/8/46 (month) (day) (year)
Cemetery or crematory: Rockville Union Cem
Location: Rockville, Md.
18. Funeral director: Wm Reuben Humphrey
Address: Bethesda Md.

19. Jan 8 1946 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 5 1946, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral edema	1 day
Due to: acute alcoholism	1 wk.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D.
Dep. Med. Exam
M. D. or other
Address: Gaithersburg Md. Date signed 1-8-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

00748

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
U. S. NAVAL HOSPITAL Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2745 29 th St. NW Wash., D.C.
(If rural, give LOCATION)

2.(a) If veteran, name war: ~~World War II~~ World War I ✓

3.(a) FULL NAME
MEHLHOP, Clarence Warren

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W*US	married

6.(b) Name of husband or wife: Mathilde Myers Mehlhop
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 19, 1872

8. AGE: Years	Months	Days	If less than one day
73	9	18	hrs. min.

9. Birthplace: Iowa
(Town, county, and state)

10. Usual occupation: Doctor

11. Industry or business

FATHER
12. Name: John Mehlhop
13. Birthplace: Germany

MOTHER
14. Maiden name: Rebecca Bruening
15. Birthplace: Germany

16. Informant: Mrs. Mathilde Myers Mehlhop
Address: 2745 29 ths St. NW Wash., D C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-22-46 (month) (day) (year)

Cemetery or crematory: Arlington, National

Location: Arlington, Va.

18. Funeral director: Joseph Gawlers and Son

Address: 1756 Pa. Ave. NW Wash., D.C.

19. 1-19 19 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 January 19 46 at 1055 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8 Jan 19 46 to 19 Jan 19 46 and that I last saw him alive on 19 Jan 19 46

Immediate cause of death	DURATION
Uremia	10 days
Due to Chr. Nephritis	Indef.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. H. Smith, Comdr. (MC) USNR

Address: USNH Bethesda, Md. M. D. or other

Date signed: 1-19-46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S-C)

CERTIFICATE OF DEATH

01749

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mons., 12 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 6 Mons., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Michigan County:

City or town: Grosse Ille
(If outside city or town limits, write RURAL and give nearest town)

Street No. 21004 E. River Road
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: William Charles MELANSON, Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Andrea Melanson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-2-18

8. AGE: Years	Months	Days	If less than one day
27	8	14	hrs. min.

9. Birthplace: Mass. (Town, county, and state)

10. Usual occupation: Navy

11. Industry or business:

FATHER
12. Name: Wm. Charles Melanson, Sr.
13. Birthplace: Canada

MOTHER
14. Maiden name: Amelia Elipp
15. Birthplace: New York

16. Informant: wife: Mrs. Andrea Melanson
Address: 21004 E. River Road, Grosse Ille, Mich.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 18, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Geo. W. Wise JCF.
Address: 2900 M St., N. W., Wash., D.C.

19. 1-17 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 16 January 19 46, at 4:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 July 19 45, to 16 Jan 19 46 and that I last saw h... im alive on 16 January 19 46

Immediate cause of death	DURATION
Metastatic Teratoma of Lungs	3 mo
Due to: Teratoma of Testicle	1 yr
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Teratoma of Testicle Date of op.

Autopsy results: Metastases to Lungs + abdomen

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Calvin T Klopp LT (jg) MC USNR M. D. Other

Address: US NH Bethesda, Md. Date signed: 1-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1/24/46 T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(11750)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 hours

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 11 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County: Washington

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No. Apt. 512 A, Weschester Apts. 3900
(If rural, give LOCATION) Cathedral Avenue

2.(a) If veteran, name war: V

3. (a) FULL NAME: MICHEL, Carl

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Eloise F. Michel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 4, 1890

8. AGE:

Years	Months	Days	If less than one day
55	7	30	..... hrs. ..... min.

9. Birthplace: Ill.
(Town, county, and state)

10. Usual occupation: U.S. Coast Guard

11. Industry or business:

FATHER
12. Name: Herman M. Michel
13. Birthplace: AlsaceLorraine

MOTHER
14. Maiden name: Pauline Mitzger
15. Birthplace: AlsaceLorraine

16. Informant: wife: Mrs. Eloise F. Michel
Address: 3900 Cathedral Avenue, Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1-7-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. Hines by JJH

Address: 2901 14th St., N. W., Wash., D.C.

19. 1-4 (Date rec'd by registrar) 1946 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 Jan 1946, at 12:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Jan 1946, to 3 Jan 1946 and that I last saw him alive on 3 Jan 1946.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	18hrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. R. McCombs, Lt. Cdr. (MC) USNR
M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 1-4-46

(1/8/46)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

06751

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg Co,
City or town: Bethesda, Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg
City or town: Gaithersburg,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Summit Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William L. Miller

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillie D Mills
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Sept 24 1888

8. AGE: Years	Months	Days	If less than one day
1888 57	3	22	hrs. min.

9. Birthplace: Montg Co, Md,
(Town, county, and state)

10. Usual occupation: Barber.

11. Industry or business:

FATHER
12. Name: Thomas Mills
13. Birthplace: Md.

MOTHER
14. Maiden name: Susan Day
15. Birthplace: Md

16. Informant: Lillie D Mills
Address: Gaithersburg .Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/19/46 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg, Md.

19. Jan 17 1946 (Date rec'd by registrar) Absalom L. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 16 19 46 at 9.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 to Jan 16 19; and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage due to	Instantly
compound fracture of skull	
Due to (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 1-16-46
Where did injury occur? Bethesda (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?): highway
Means of injury: auto. accident Injured at work? ? no

23. SIGNATURE: Frank J. Broccolato M.D. (M. D. or other)
Address: Gaithersburg Md Date signed 1-17-46

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

06752 Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Suburban Hospt.
How long in hospital or institution? 1 day 22 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5415 Roosevelt St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Springs Reid Moore.
3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mary F. Moore
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) July 16, 1893

8. AGE: Years 52 Months 6 Days 5 If less than one day ... hrs. ... min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual occupation Govt. Auditor
11. Industry or business

FATHER
12. Name
13. Birthplace York Co. South Carolina

MOTHER
14. Maiden name Emilie McCully
15. Birthplace York Co. South Carolina

16. Informant Mrs. Moore
Address 5415 Roosevelt St.

17. Burial Date thereof 1/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rockville Union Cem.
Location Rockville, Maryland
19. Funeral director Wm. Reuben Pumphrey
Address Bethesda Maryland

19. 1/23 1946 Wm E. Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/21/46 19... at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1941, to Jan 21 1946
and that I last saw him alive on Jan 21 1946

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to Hypertension	12 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [illegible] M.D.
M. D. or other
Address 5016 Lexington Rd Date signed 1/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17A)

CERTIFICATE OF DEATH

0755

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, Institution, or street address where death occurred:

24 Franklin st

How long in hospital or Insfitution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charlotte A. Moran

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7, 1935

8. AGE: Years	Months	Days	If less than one day
10	5	26	..... hrs. ..... min.

9. Birthplace Wash. DC (Town, county, and state)

10. Usual occupation Student

11. Industry or business —

FATHER 12. Name John E. Moran

13. Birthplace D.C.

MOTHER 14. Maiden name Elizabeth Gaisberg

15. Birthplace D.C

16. Informant Robert Moran

Address 1349 Taylor St NW. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7, 1946 (month) (day) (year)

Cemetery or crematory Rock Creek

Location Wash DC

18. Funeral director W. Warren Tallarnd

Address 3619 - 14th St NW. DC.

19. 1/6 (Date rec'd by registrar) 19 46 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 19 46, at 1 hrs. 5 min. AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 med Exam case 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Asphyxia	Found dead in bed
Due to Inflammatory gas (poisoning accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please nuderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 1-3-46

Where did injury occur? Kensington (City or town) Monty (County) Md (State)

Injured at home, farm, indusfry, public place (where?) home

Means of injury leak in gas pipe Injured at work? no

23. SIGNATURE Frank J. Broschart M.D. M. D. or other

Address Off med. Exam Date signed 1-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-A)

CERTIFICATE OF DEATH

(1)754

Reg. Dist. No. 216

1. PLACE OF DEATH

County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, Institution, or street address where death occurred:

24 Franklin St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 Franklin St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

(Mrs) Elizabeth G. Moran

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: John E. Moran

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 1, 1907

8. AGE: Years	Months	Days	If less than one day
38	3	2	..... hrs. ..... min.

9. Birthplace: Wash. D.C. (Town, county, and state)

10. Usual occupation: NONE.

11. Industry or business: —

FATHER

12. Name: Charles J. Gaisberg

13. Birthplace: D.C.

MOTHER

14. Maiden name: Unknown

15. Birthplace

16. Informant: Robert Moran

Address: 1349 Taylor St NW. DC.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7, 1946 (month) (day) (year)

Cemetery or crematory: Rock Creek

Location: Wash. D.C.

18. Funeral director: W Warren Tallsmith

Address: 3619-14th St NW. DC.

19. 1/6 (Date rec'd by registrar) 1946 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1946, at Univ. Hosp.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 31 Med. Exam case 19 ..... to ..... 19 .....

and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Asphyxia	Time between onset and death
Due to: electrocuting gas	
Jaming (Accidental)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 1-3-46

Where did injury occur? Kensington (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) home

Means of injury leaking gas pipe Injured at work? no

23. SIGNATURE: Frank J. Bronchart M.D.

Dep. Med. Examiner, M. D. or other

Address: Gaithersburg Md Date signed 1-4-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-A)

00753

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, institution, or street address where death occurred: 24 Franklin St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington (If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Franklin St (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME (Miss) Elizabeth G. Moran
3. (b) Social Security Number

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife: —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Dec 28, 1928

8. AGE: Years	Months	Days	If less than one day
17	0	5	... hrs. ... min.

9. Birthplace: Wash. D.C. (Town, county, and state)
10. Usual occupation: Student
11. Industry or business: —
FATHER 12. Name: John C. Moran
13. Birthplace: D.C.
MOTHER 14. Maiden name: Elizabeth Gaisberg
15. Birthplace: D.C.
16. Informant: Robert Moran
Address: 1349 Taylor St NW D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 7 1946 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Wash D.C.
18. Funeral director: W. Warren Taltavull
Address: 3619-14th St NW D.C.
19. 1/7 1946 (Date rec'd by registrar) Wm E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1946, at 1:00 5 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. care 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Asphyxia
Due to: illuminating gas poisoning
Due to: (accidental)
DURATION: found dead in bed

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accidental Date of 1-3-46
Where did injury occur? Kensington (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: gas pipe leak Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md Date signed 1-4-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(1787)

00756

Reg. Diat. No. 2-16

1. PLACE OF DEATH:

County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

24 Franklin St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 24 Franklin St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 2

3.(a) FULL NAME: John E. Moran

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

B.(b) Name of husband or wife: Elizabeth G.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10, 1907

8. AGE: Years	Months	Days	If less than one day
38	6	23	..... hrs. ..... min.

9. Birthplace: Wash. D.C. (Town, county, and state)

10. Usual occupation: R.F.C.

11. Industry or business: U.S. Government

FATHER — 12. Name: Allen C. Moran

FATHER — 13. Birthplace: Wash. D.C.

MOTHER — 14. Maiden name: Genevieve Nash.

MOTHER — 15. Birthplace: Pa.

16. Informant: Robert A. Moran

Address: 1349 Taylor St NW D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 7, 1946. (month) (day) (year)

Cemetery or crematory: Rock Creek.

Location: Wash. D.C.

18. Funeral director: W. Warren Tattersall

Address: 3619-14th St N.W. Wash DC.

19. 1/6 (Date rec'd by registrar) 1946 Wm E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 1946 (month) (day) (year) M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxia	Found dead in room.
Due to Exhilarating gas	
Gassing	
Due to (accidental)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accidental Date of 1-3-46

Where did injury occur? Kensington (City or town) Mont. (County) Md (State)

Injured at home, farm, Industry, public place (where?) Home

Means of injury: Asphyxia Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D.

Dep. Med. Exam M. D. or other

Address: Gaithersburg Md Date signed 1-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-A)

CERTIFICATE OF DEATH

00757

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, Institution, or street address where death occurred:
24 Franklin St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Franklin St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Patricia L Moran

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 12, 1930

8. AGE: Years	Months	Days	If less than one day
15	0	21	..... hrs. ..... min.

9. Birthplace: Wash D.C.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business: —

FATHER — 12. Name: John E. Moran
13. Birthplace: D.C.

MOTHER — 14. Maiden name: Elizabeth Gaisberg
15. Birthplace: D.C.

16. Informant: Robert Moran
Address: 1349 Taylor St NW. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7, 1946 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Wash. D.C.

18. Funeral director: (W. Warner Tattersall)
Address: 3619 - 14th St NW DC.

19. 1/6 (Date rec'd by registrar) 1946 Wm E Jarboe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 3 19 46 at [illegible] P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 Med. Exam Case 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Asphyxia	2 or 3 days
Due to illuminating gas poisoning	Accidental
Due to Accidental	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of 1-3-46
Where did injury occur? Kensington (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?) home
Means of injury: leak in gas pipe Injured at work? no

23. SIGNATURE: Frank J. Bronhart M.D.
M. D. or other
Address: Gaithersburg Md Date signed 1-4-46

VS/A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00758

Reg. Dist. No. 193

1. PLACE OF DEATH:
County: Montgomery
City or town: Long Corner MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Long Corner MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Raymond Lee Murray

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bessie C. Murray
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Aug 10 1893

8. AGE: Years	Months	Days	If less than one day
50	4	22	hrs. min.

9. Birthplace: Howard County MD.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm

FATHER
12. Name: Matthew Murray
13. Birthplace: Howard County MD.

MOTHER
14. Maiden name: Susan Jane Molesworth
15. Birthplace: Howard County MD.

16. Informant: Mrs. Bessie C. Murray
Address: Mount Airy MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4 th 194[illegible] (month) (day) (year)
Cemetery or crematory: Howard Chapel
Location: Howard County MD.

19. Funeral director: Roy W. Barber MD.
Address: Laytonsville

19. Jan. 3, 1946 (Date rec'd by registrar) E. Pearl Mercier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1, 1946, at 6:10 P

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 15, 1945, to January 1 1946
and that I last saw him alive on January 1, 1946

Immediate cause of death	DURATION
Carcenomatosis of abdomen	7 mo.
Due to: Undetermined at exploratory operation.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: general carnenomatosis of viscera external to intestines. Date of op. Aug. 25, 1945
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Stanley Grabill M. D. or other
Address: Mt Airy Md Date signed 1/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-C)

CERTIFICATE OF DEATH

00759

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
U. S. NAVAL Hospital Bethesda, Md.

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Penna. County:

City or town: Aliquippa
(If outside city or town limits, write RURAL and give nearest town)

Street No. 520 Franklin Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

Evelyn (R) NADDOUR, Y3c V-10 USNR

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 12 1921

8. AGE:	Years	Months	Days	If less than one day
	24	8	15	hrs. min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: U. S. NAVY

11. Industry or business

FATHER
12. Name: Charles Naddour
13. Birthplace: Pa

MOTHER
14. Maiden name: Nanira Ghattas Naddour
15. Birthplace: Pa.

16. Informant: Mrs. Charles Naddour
Address: 520 Franklin Ave. Aliquippa.

17. removal (Burial, cremation, or removal. Which?) Date thereof Jan. 29, 1946 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Aliquippa, Pa.

18. Funeral director: George W. Wise Co. J.C.F.

Address: 2900 M St. N.W., Washington, D.C.

19. 27 January 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27 19 46 at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Intra-cranial hemorrhage	2 days
Due to fracture of base of skull (accidental)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 1-28-46

Where did injury occur? U.S. Route #1 Fairfax Co. Va.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: Auto accident Injured at work? No

23. SIGNATURE: Frank J. Broschart M.D. Dep. Med. Exam M. D. or other

Address: Fredericksburg Md. Date signed 1-27-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

06760

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: 605 - Anderson Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 605 Anderson Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dorsey W. Nicholson

3.(b) Social Security Number: 212-24-3920

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Rosie Lee Nicholson
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): March 18 - 1876
8. AGE: Years: 69 Months: 10 Days: 8 If less than one day: hrs. min.
9. Birthplace: Boyds - Maryland (Town, county, and state)
10. Usual occupation: Employee - Health Center
11. Industry or business:
FATHER 12. Name: John T. Nicholson
13. Birthplace: Clarksburg - Monty Co - Md
MOTHER 14. Maiden name: Mary E. Pickrell
15. Birthplace: Near Clarksburg - Monty Co - Md
18. Informant: Mrs. Rosie Lee Nicholson (wife)
Address: 605 - Anderson Ave Rockville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 29/46 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Near Rockville - Md
18. Funeral director: Wm. Reuben Pumphrey
Address: Rockville - Maryland
19. 1/26/46 (Date rec'd by registrar) Josephine D. Horton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 24 1946 at 12.10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/24/41 1945 to Jan 24 1946 and that I last saw h-- alive on Jan 24 1946

Immediate cause of death	DURATION
Angina Pectoris	
Due to: Arteriosclerosis	
Due to:	
Other conditions: Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. E. Hawks M D
M. D. or other
Address: Rockville Md Date signed: 1/24/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-E)

CERTIFICATE OF DEATH

00761

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Cabin John (If outside city or town limits, write RURAL and give nearest town)

Street No. Cedar Lane (If rural, give LOCATION)

2.(a) If veteran, name war NO

3. (a) FULL NAME John Thomas Oden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife Mary Jane Canter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 20 1861

8. AGE:

Years	Months	Days	If less than one day
84	9	13	..... hrs. ..... min.

9. Birthplace Maryland Montgomery Co (Town, county, and state)

10. Usual occupation Farming

11. Industry or business

MOTHER FATHER

12. Name Geo. Washington Oden

13. Birthplace Montgomery Co Maryland

MOTHER

14. Maiden name Hilda Elizabeth Arnold

15. Birthplace Frederick Co Maryland

16. Informant Mrs Bessie Va. Allen (Daughter)

Address Cabin John Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/6/46 (month) (day) (year)

Cemetery or crematory Potomac Cemetery

Location Potomac Maryland

18. Funeral director Wm Reuben Humphreys

Address Bethesda, Md.

19. 1/6 1946 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/ 1946, at 10:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/19 1945, to 1/2 1946; and that I last saw h... alive on 1/2/46 19..

Immediate cause of death	DURATION
Pneumonia	
Due to Gen'l debility	
Due to Chronic Alcohol Thrombosis	
Other conditions Prostatism	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Dr. S T Kimble, Jr. M.D. (M.D. or other)

Address Bethesda Suburban Hosp. Date signed 1/2/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47 (7)

CERTIFICATE OF DEATH

0762

Reg. Dist. No. 2-23

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, 12.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Five months 23 days

Hospital, Institution, or street address where death occurred:
The Washington Sanitarium and Hospital

How long in hospital or institution? Five months, 23 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pennsylvania County

City or town Harrisburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1800 Green Street
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Jesse Oliver Oren

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mrs. Katherine Oren

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 17, 1892

8. AGE:

Years	Months	Days	If less than one day
53	4	20	..... hrs. ..... min.

9. Birthplace Newport, Perry Co. Penna.
(Town, county, and state)

10. Usual occupation Electrical Repairs

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

16. Informant Hospital Records.

Address Takoma Park, 12.

17. Burial Date thereof Jan 9, 1946.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Enola Cemetery

Location Enola, Penna.

18. Funeral director Arthur Walters

Address 254 Carroll St. N.W. Wash. D.C.

19. Jan 8 1946 Wm Dell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6 1946, at 10:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13 1945, to Jan 6 1946 and that I last saw h.. alive on Jan. 5 1946

	DURATION
Immediate cause of death: Exanition	Terminal
Due to: Carcinoma of Lung with Metastases	9 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Confirmed Clinical Diagnosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert A Harsch M. D. or other

Address Takoma Park Md. Date signed 1/6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93a)

06763

CERTIFICATE OF DEATH

Reg. Diat. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County Montgo. Co.

City or town Scotland, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:

(For newborn infants give residence of mother)

State Maryland County Montgo. Co

City or town Scotland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Payne

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of ~~husband~~ or wife Ella Payne

6.(c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years 27 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Payne

13. Birthplace Va.

MOTHER 14. Maiden name Florence Nickens

15. Birthplace Va.

16. Informant Ella Payne

Address Scotland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 16 1946 (month) (day) (year)

Cemetery or crematory Scotland

Location Scotland, Md

18. Funeral director Robert L Snowden

Address 246 N. Washington St Rockville

19. 1/16/46 (Date rec'd by registrar) Josephine D. Watson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/13 1946, at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death — DURATION

Apo autopsy 1/13/46

Due to (cause not determined)

Due to until laboratory findings are completed

Other conditions Findings c Acute myocarditis c w.b.c.

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op...

Autopsy results Findings Negative

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1/13/46

Where did injury occur? Scotland (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Injured at work?

23. SIGNATURE J. W. Bain Certifying Physician M. D. or other

Address Sandy Spring, Md Date signed 1/16/46

00764

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital Inc.
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Germantown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Rhoda A. Poole

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	W

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1871

8. AGE: Years 74 | Months 10 | Days 26 | If less than one day hrs. min.

9. Birthplace Claggettsville, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name James Poe

13. Birthplace Montgomery Co., Md.

MOTHER 14. Maiden name

15. Birthplace

16. Informant Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 2 1946 (month) (day) (year)

Cemetery or crematory Damascus, Md.

Location Montgomery Co., Md.

18. Funeral director Roy W. Barber

Address Laytonsville, Md.

19. Feb 2, 1946 (Date rec'd by registrar) Gertrude S. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1946, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24 1946, to January 30 1946 and that I last saw her alive on January 30 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	7 days
Due to General arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Sandy Spring, Md. Date signed 1/31/46

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00765

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH

County: Montgomery

City or town: Derwood

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Derwood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roberta Mullican Ricketts

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles C. Ricketts

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 3 - 1868

8. AGE: Years 78 | Months 0 | Days 33 | If less than one day: hrs. min.

9. Birthplace: Derwood - Mont. Co - Md. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: John Mullican

13. Birthplace: Derwood - Md

MOTHER — 14. Maiden name: Rachel Ricketts

15. Birthplace: Derwood - Md

16. Informant: Thomas Trail Mullican

Address: Derwood - Md -

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30/46 (month) (day) (year)

Cemetery or crematory: Forest Oak

Location: Gaithersburg Mont. Co - Md

18. Funeral director: Wm. Rankin Humphrey

Address: Rockville - Maryland

19. 1/27/46 (Date Rec'd by registrar) Josephine D. Hutton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1946 at 11 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to Jan. 26 1946

and that I last saw h alive on June 11, 1946

Immediate cause of death	DURATION
acute cardiac dilatation	½ hour.
Due to: Myocarditis	
Contrary arteriosclerosis	2 years.
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. R. Smithson, M.D. (M. D. or other)

Address: Rockville, Md. Date signed: 1/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

00766

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 4th St. S. E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: SAKSA, Baby Boy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1-23-46

8. AGE: Years	Months	Days	If less than one day
		1	7 hrs. min.

9. Birthplace: Bethesda, Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Richard W. Saksa

13. Birthplace: Conn.

MOTHER — 14. Maiden name: Lois Warren

15. Birthplace: N.J.

16. Informant: fa: Mr. Richard W. Saksa

Address: 14 4th St., S. E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1-25-46 (month) (day) (year)

Cemetery or crematory: George Washington Memorial

Location: Maryland (Hyattsville)

18. Funeral director: W. W. Chambers

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 1-24 19 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 January 19 46 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-23- 19 46, to 1-24- 19 46

and that I last saw him alive on 1-24- 19 46

Immediate cause of death	DURATION
Asphyxia	
Due to: Immaturity	
Due to: 7 mos premature	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. W. Robertshaw A. W. ROBERTSHAW, Comdr. (MC) USNR M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

00767

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 205 Hartwell Road.

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3.(a) FULL NAME: KATIE APEL SCHLOSSER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John G. Schlosser

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 3, 1870

8. AGE: Years	Months	Days	If less than one day
75	6	28	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER — 12. Name: William Apel

13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Germany

16. Informant: Mr. John G. Schlosser

Address: 205 Hartwell Rd. Sil. Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 2, 1946 (month) (day) (year)

Cemetery or crematory: Rock Creek Cemetery, D.C.

Location: Washington, D. C.

18. Funeral director: S. H. Hess Co.

Address: 2901 14th St., N. W. Wash., D.C.

19. Jan 29 1946 (Date rec'd by registrar) Josephine M. Shaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31 1946 at 4:30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 19 1946, to Jan 31 1946 and that I last saw h.. alive on Jan 30 1946

Immediate cause of death	DURATION
CARDIAC DILATATION	1 day
Due to	
Due to	
Other conditions: Hypertension - old age	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm A. Schumann M.D. M. D. or other

Address: 113 Carroll St N W Date signed: 1-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (153)

00768

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 162 days

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 162 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: North Carolina County:

City or town: Gibsonville,
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: SCHOOLFIELD, Herbert Archer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	Married

6.(b) Name of husband or wife: Kodell Mae Schoolfield

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 11 1907

8. AGE: Years	Months	Days	If less than one day
38	11	7	hrs. min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: U. S. NAVY

11. Industry or business:

FATHER — 12. Name: James Schoolfield
13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Asla Carter
15. Birthplace: North Carolina

18. Informant: Wife: Mrs. Kolell Mae Schoolfield
Address: GIBSONVILLE, N. C.

17. removal (Burial, cremation, or removal. Which?) Date thereof 1-19-46 (month) (day) (year)

Cemetery or crematory:

Location: Gibsonville, N. C.

18. Funeral director: Geo. W. Wise J.C.F.
Address: 2900 M St., N. W., Wash., D.C.

19. 1-19- 1946 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 Jan 1946, at 1055PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Aug 1945, to 18 Jan 1946
and that I last saw him alive on 18 Jan 1946

	DURATION
Immediate cause of death: Pneumonia	
Due to: Pemphigus	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. G. BARKSDALE, Comdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1/24/46

Rockville 48-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00769

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery County

City or town: Bethesda Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3-10-10 - 2-15-46.

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 3-10-10 to 2-15-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bertrand A. Shear.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m.	w.	m.

6.(b) Name of husband or wife: Lorando Shear

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 10 - 1910 -

8. AGE:

Years	Months	Days	If less than one day
35	10	4	..... hrs. ..... min.

9. Birthplace: Wheeling West Va

(Town, county, and state)

10. Usual occupation: Operator

11. Industry or business: Potomac Sealcoat Corp.

FATHER 12. Name: Harry D. Shear

13. Birthplace: Va

MOTHER 14. Maiden name: Mary Thompkins.

15. Birthplace: Va.

18. Informant: Chas. - (given by wife).

Address

17. Jan. 15th Removal Date thereof Jan 1946 1-19-1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Cameron W. Va

Location: Marshall Co W Va

18. Funeral director: Roy W Barber

Address: Taftonsville W Va

19. 1/15 1946 Mr E Jobes

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH: January 15 1945 at 3:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12-13 1945, to Jan 15 1946

and that I last saw h.i.m. alive on 1946

Immediate cause of death	DURATION
Nephritis	
Chronic glomerulo-nephritis. Cerebral	
Due to Duration: 22 years.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Dr. S. T. Kimble, Jr.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Dr. S. T. Kimble Jr. M. D. or other

Address: Suburban Hospital Bethesda Md Date signed 1/15/46.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH

County: Montg.

City or town: Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3

Hospital, Institution, or street address where death occurred: Walter Johnson Hosp.

How long in hospital or institution? 3 –

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md. County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 811 Thayer Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Anna Lewis Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widowed

6.(b) Name of husband or wife: Benjamin F. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 16 1862

8. AGE: Years 84 | Months 11 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace: Fort Loudon Penna. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Reuben Lewis

FATHER — 13. Birthplace: Fort. Loudon Penna.

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace:

16. Informant: Mrs. Grace Hausmann

Address: 811 Thayer Ave. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof January 22, 1946 (month) (day) (year)

Cemetery or crematory: Roswell Cemetery

Location: Roswell, New Mexico

18. Funeral director: Hilton & Walton

Address: 25 Carroll Ave. Takoma Park, D.C.

19. Jan 18 1946 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 17 1946, at 5-50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18 1945, to Jan 17 1946

and that I last saw h[illegible] alive on ..... 19.....

Immediate cause of death	DURATION
Abst of Sigmoid	24 hrs
Due to Cancer of Sigmoid	
Due to Abse in pelvis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma caused Abst. Ca of bowel and abse. formation Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Howard T. Morse M.D. M. D. or other

Address: 78 Carroll Ave Takoma Park Md. Date signed: 1/17/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77d

CERTIFICATE OF DEATH

016771

★ Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery

City or town Washington Grove Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural Washington Grove
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Kirby F Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Audrey S Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 20 - 1897

8. AGE: Years 48 | Months 1 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Miles West Va
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Health Institute Bethesda

FATHER 12. Name George F Smith

13. Birthplace Miles West Va

MOTHER 14. Maiden name Sarah J Wetzel

15. Birthplace Pendelton Co West Va

16. Informant Audrey S Smith

Address Washington Grove md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 30 1946 (month) (day) (year)

Cemetery or crematory St Lukes Cemetery

Location Rockville md

18. Funeral director Roy W Barber

Address Laytonsville md

19. Jan 29 1946 Alvada L Poole
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 27 - 1946 at 5:45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 27 - 1946 to Jan - 27 - 1946 and that I last saw h... alive on Jan 27 - 1946

Immediate cause of death	DURATION
acute Cardiac dilatation	1-2 days
Due to chronic alcoholism	20 or more years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William E. Miller M.D.
M. D. or other

Address Gaithersburg Md Date signed 1/29/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06772

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:
County: Montgomery
City or town: Boyd - R.F.D
(If outside city or town limits, write RURAL und give nearest town)
How long in above place of death? 49
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewborn lofants give residence of mother)
State: Md County: Montg
City or town: Boyd - R F D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JAMES E SPRING

3.(b) Social Security Number: 577-24-2990

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary C. Spring
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Jan 29 - 1871

8. AGE: Years	Months	Days	If less than one day
74	11	14	hrs. min.

9. Birthplace: Taylorstown, Va. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business
FATHER — 12. Name: James Spring
FATHER — 13. Birthplace: Va.
MOTHER — 14. Maiden name: Mary Davis
MOTHER — 15. Birthplace: Va
16. Informant: Earl Spring
Address: Boyd - R.F.D, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/46 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Clarksburg, Md
18. Funeral director: William B Hilton
Address: Barnesville, Md
19. Jan. 15 1946 (Date rec'd by registrar) Mrs. C.C. Hilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 Jan 1946 at 7 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Jan. 1946, to 12 Jan 1946 and that I last saw h.im alive on 12 Jan. 1946

Immediate cause of death	DURATION
Chronic nephritis (131) with ascites	1 year
Due to: Arteriosclerosis (97)	20 years
Due to: Senility (162)	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please ouderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo. D. Kelly, M.D. M. D. or other
Address: Dawsonville, Md. Date signed: 14 Jan 1946

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

00773

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium Hospital

How long in hospital or institution? 50 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State District of Col. County

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1432 Madison St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Stickney, Mr. Benjamin Rollin

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Harriet Amanda Stickney

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 4, 1871

8. AGE:

Years	Months	Days	If less than one day
74	8	17	hrs. min.

9. Birthplace Port Henry New York.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Mr. Darius Stickney

13. Birthplace

MOTHER 14. Maiden name Miss Daphne Loomis

15. Birthplace

16. Informant Mr. Malcolm Clough Stickney

Address 200 W. College Terrace, Frederick Md.

17. (Burial, cremation, or removal. Which?) Date thereof 1-23-46 (month) (day) (year)

Cemetery or crematory

Location Port Henry, N.Y.

18. Funeral director William Leis Sons

Address 300-4th St. N.E.

19. Jan 22 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21, 1946, at 5:37 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2, 1945, to Jan. 21, 1946 and that I last saw h. alive on Jan. 21, 1946

	DURATION
Immediate cause of death Carcinoma of Lung	2 mos
Due to Carcinoma of Sigmoid	1 yr?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Sigmoid Date of op. 12-19-45

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul V. Starr, M.D.
M. D. or other

Address Takoma Park, Md. Date signed 1-21-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

11774

Reg. Dist. No. 2-6

1. PLACE OF DEATH:

County Montgomery

City or town Cabin Johns

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos

Hospital, Institution, or street address where death occurred:

70 Main St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Cabin Johns

(If outside city or town limits, write RURAL and give nearest town)

Street No. 70 Main St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George R. Swainson

3.(b) Social Security Number 212-24-4476

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 25 1868

8. AGE: Years	Months	Days	If less than one day
77.			..... hrs. ..... min.

9. Birthplace New York (Town, county, and state)

10. Usual occupation Machinist helper

11. Industry or business

FATHER 12. Name Arthur Swainson

13. Birthplace New York

MOTHER 14. Maiden name

15. Birthplace unknown

16. Informant W. E. Swainson

Address Cabin John, Md.

17. Removal (Burial, cremation, or removal. Which?) Burial

Date thereof Jan. 30, 1946 (month) (day) (year) Feb. 2, 1946

Cemetery or crematory

Location

18. Funeral director W. W. Chambers Co.

Address 3072 M. St. N.W. Wash. D.C.

19. 1-30 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1946 at 6:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to Med. Exam Case 19

and that I last saw h alive on 19

	DURATION
Immediate cause of death	
Coronary occlusion	Immediate death in home
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brockhaus M.D. M. D. or other

Address Gaithers Comp. Md. Date signed 1-30-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

00775

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mons., 11 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 mons., 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Takoma Park
(If outside city or town limits, writs RURAL and give nearest town)

Street No.: 7025 Eastern Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: TARWATER, Clara Maude, dependent

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 21, 1877

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	9	26		

9. Birthplace: Mo.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: W. T. Bailey
13. Birthplace: Mo. dec

MOTHER
14. Maiden name: Emily Davis
15. Birthplace: Ky. dec.

16. Informant: son: Charles F. Tarwater, Sp(PhoM)1c
Address: 7025 Eastern Avenue, Takoma Park, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 1-19-46 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln

Location: Washington, D. C.

18. Funeral director: Takoma Funeral Home By E. M. Riley

Address: 254 Carroll Avenue, N. W., Wash., D.C.

19. 1-17 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 Jan 19 46 at 10:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Oct. 19 45 to 17 Jan 19 46 and that I last saw h...er alive on 17 Jan 19 46

Immediate cause of death	DURATION
Coronary heart disease, arteriosclerotic	12 mos
Due to:	
Due to:	
Other conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: T. S. Barnes
T. S. BARNES, Lt. Cdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 1-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

4/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1246)

CERTIFICATE OF DEATH

011776

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2days - 6 hrs

Hospital, Institution, or street address where death occurred:
Suburban Hosp.

How long in hospital or institution? 2days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4009 Oliver St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Mae Thayer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single, married~~, widowed, ~~or divorced~~
F	W	W

6.(b) Name of husband ~~or wife~~ Burton Thayer (deceased)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 22, ? Unknown yr.

8. AGE:

Years	Months	Days	If less than one day
74 (?)			..... hrs. ..... min.

9. Birthplace Brooklyn New York
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Geo. Keating
13. Birthplace Brooklyn, New York

MOTHER
14. Maiden name
15. Birthplace Brooklyn New York

16. Informant Mrs Ethel M. Freile

Address 4009 Oliver St - Beth. Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 1/14/46 (month) (day) (year)

Cemetery or crematory Ft. Lincoln

Location Wash. D.C.

18. Funeral director S.H. Ames Co

Address 2901-14th St N.W. Wash D.C.

19. 1/17 19 46 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 19 46, at 6:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Uremia	24 hours
Due to Arteriosclerotic Cardio Nephritic Failure	
Due to	
Due to	
Other conditions Cirrhosis of Liver 4 years Varix of Oesophagus 3 days	

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. .....

Autopsy results Ruptured esophageal Varix

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Bradley D Hodgkiss MD
M. D. or other

Address 313 W Bradley Lane Date signed 1/12/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

011777

Reg. Dist. No. 223-

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, institution, or street address where death occurred:
214 Tulip Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County: MONTGOMERY
City or town: TAKOMA PARK
(If outside city or town limits, write RURAL and give nearest town)
Street No. 214 Tulip Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: HARRY S. THOMAS

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	MARRIED

8.(b) Name of husband or wife: LOUISA R. THOMAS
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): FEB. 21, 1869.

8. AGE:

Years	Months	Days	If less than one day
76	10	29	hrs. min.

9. Birthplace: WASHINGTON, D.C.
(Town, county, and state)
10. Usual occupation: COMMISSION MERCHANT.
11. Industry or business: WHOLESALE & RETAIL
FATHER 12. Name: VAN BUREN THOMAS
13. Birthplace: MARYLAND
MOTHER 14. Maiden name: RACHEL JANE BEVANS
15. Birthplace: MARYLAND
16. Informant: Mrs. Louisa R. Thomas
Address: 214 Tulip Ave. Takoma Park, Md.
17. Buried (Burial, cremation, or removal, Which?) Date thereof Jan. 22, 1946 (month) (day) (year)
Cemetery or crematory: Glenwood Cemetery
Location: Washington, D.C.
18. Funeral director: Walter E. Talbert
Address: 7610 Carroll St., Takoma Park, Md.
19. Jan 20 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 20 1946, at 11:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945, to Jan 20 1946
and that I last saw him alive on Jan 19 1946

Immediate cause of death	DURATION
Gangrene left foot and leg	16 mo
Due to arteriosclerosis	20 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Carroll M.D.
Address: 6801-6th St. N.W. Wash. D.C. M. D. or other
Date signed: 1/20/46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-C) X

CERTIFICATE OF DEATH

00778

216

Reg. Dist. No.

FILM No. I 0 0 FEB 26 1946

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Tenn. County:

City or town: Memphis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 197 Mill Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: THOMPSON, Jewell Clyde

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Ernestine Thompson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 19, 1919

8. AGE: Years	Months	Days	If less than one day
26 ~~25~~	3	3	hrs. min.

9. Birthplace: Mo
(Town, county, and state)

10. Usual occupation: Navy

11. Industry or business

FATHER — 12. Name: Louis L. Thompson
13. Birthplace: Mo.

MOTHER — 14. Maiden name: Gladys Holmes
15. Birthplace: Mo.

16. Informant: wife: Mrs. Ernestine Thompson
Address: 197 Mill Avenue, Memphis, Tenn.

17. removal (Burial, cremation, or removal. Which?) Date thereof 1-23-46 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: Memphis, Tenn.

18. Funeral director: Geo. W. Wise. J.C.F.

Address: 2900 M St., N. W., Wash., D.C.

19. 1-23- 46 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 January 19 46 at 5:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Jan 19 46 to 22 Jan 19 46 and that I last saw him alive on 22 Jan 19 46

Immediate cause of death	Pneumothorax, spontaneous, bilateral	
Due to	Mediastinal emphysema	
Due to		
Other conditions		

DURATION

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of thyroid gland with regional metastases. Date of op. 4-22-46

Autopsy results: Pneumothorax, spontaneous, bilateral.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

D. B. Miller, Lt. (MC) USN
23. SIGNATURE M. D. or other

Address: US N.H., Bethesda, Md. Date signed: 1-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

00779

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montg Chevy Chase Md.
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: 412 Cummings La.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montg
City or town Chevy Chase (If outside city or town limits, write RURAL and give nearest town)
Street No. 412 Cummings Lane (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JAMES A. THURMAN.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married.

6.(b) Name of husband or wife Pauline Thurman
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1900

8. AGE: Years	Months	Days	If less than one day
45	10	23	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Employed by French Govt.
11. Industry or business

FATHER
12. Name Richard B. Thurman
13. Birthplace Utah

MOTHER
14. Maiden name Cornelia Ayton
15. Birthplace Maryland

16. Informant Pauline Thurman
Address 412 Cummings La.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan. 24, 1946 (mooth) (day) (year)
Cemetery or crematory Arlington Meth. Cem.
Location Arlington, Va.
18. Funeral director Wm Reuben Pumphrey
Address Bethesda, Md.

19. 1/23/19 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1946, at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 3 1945, to Jan 21 1946 and that I last saw h... alive on Jan 14, 1945 19...

Immediate cause of death	DURATION
Acute Congestive Heart Failure	2 hrs.
Due to Chronic Myocarditis	2 mos.
Due to	
Other conditions —	

(Include pregnancy within 3 mooths of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Richard V. Mattingly M.D. M. D. or other
Address 4707 Conn Ave. NW Ward 3 DC Date signed 1/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

CERTIFICATE OF DEATH

011780

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

none

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 131 - Hesketh Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1, U.S.Navy

3.(a) FULL NAME: DR. ALBERT PERKINS TIBBETS

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine H. Tibbets

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 14, 1884

8. AGE: Years	Months	Days	If less than one day
61	2	17	..... hrs. ..... min.

9. Birthplace: Somersworth, New Hampshire
(Town, county, and state)

10. Usual occupation: Physician - M.D.

11. Industry or business: Private Practice

FATHER
12. Name: William S. Tibbets
13. Birthplace: New Hampshire

MOTHER
14. Maiden name: Carrie Perkins
15. Birthplace: New Hampshire

16. Informant: Mrs. Katherine H. Tibbets

Address: 131-Hesketh St., Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 4, 1946 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Martin W. Hysong Co.

Address: 1300 - N Street N.W., WASH. D.C.

19. 2/1 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1946 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945 to Jan 31, 1946 and that I last saw him alive on Jan 31, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage (Apoplexy)	5 days
Due to: Hypertension & Arteriosclerosis	3yrs +
Due to:	
Other conditions: Hypertensive Heart Disease	3 yrs +

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C B Conklin M.D.
M. D. or other

Address: 1801 - Eye St. Date signed: 2/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 54@

CERTIFICATE OF DEATH

011781

Reg. Diat. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Washington Sanitarium + Hospital.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Tigner, Mrs. Thelma Ruth Tigner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female F	WHITE	MARRIED

6.(b) Name of husband or wife Mr. James Andrew Tigner

December 25, 1904 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 44 Months Days 13 If less than one day hrs. min.

9. Birthplace Virginia (Town, county and state)

10. Usual occupation Real Estate Saleswoman.

11. Industry or business

FATHER 12. Name Austin Lorenz Welchons

13. Birthplace Dunkie Tawney, Penn.

MOTHER 14. Maiden name Suzie Weber Brewer

15. Birthplace White Hall, Michigan

16. Informant Washington Sanitarium + Hosp. records

Address Takoma Park, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 11, 1946 (mouth) (day) (year)

Cemetery or crematory Fort Lincoln

Location Bladensburg Rd N.E.,

18. Funeral director W. A. Chambers

Address 517-11½ St SE Wash DC.

19. Jan. 7 1946 (Date rec'd by registrar) Josephine M. Schaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 7, 1946 at 5 40 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5th 1946, to Jan. 7th 1946 and that I last saw her alive on January 7th 1946

	DURATION
Immediate cause of death Increased Intracranial pressure	3 days
Due to Pontine hemorrhages	3 days
Due to Malignant Glioma	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Malignant Glioma

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wallace U. Nook M.D. M. D. or other

Address 805 Carro 11 Avenue Takoma Park 12, Md. Date signed 1-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

001782

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred:
8600 Old Georgetown Rd. - Bethesda, Md.

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1200 Prospect Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Hilda Tillinghast

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M.

6.(b) Name of husband ~~or wife~~ Edward Tillinghast

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 9 - 1876

8. AGE: Years	Months	Days	If less than one day
69	7	25	..... hrs. ..... min.

9. Birthplace Ontario, Canada
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name James Watson
13. Birthplace ? Canada

MOTHER
14. Maiden name Cecilia McGann
15. Birthplace ? Ireland

16. Informant Mrs. Hilliams (dau.)
Address 1200 Prospect Ave. Takoma Pk. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 7 1946 (month) (day) (year)

Cemetery or crematory Ft Lincoln

Location 3201 - Bladensburg Rd

18. Funeral director Ernest A. Adams

Address 5103 - Wisconsin ave NW

19. 1/7 1946 Wm E. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1946, at 9:00 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h.. alive on ..... 19.....

Immediate cause of death	DURATION
Respiratory failure due to cerebral hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results Marked cerebral arteriosclerosis Myocardial degeneration Pulmonary infarcts

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE I. L. Marks
M. D. or other

Address 4601 Leland St. Date signed 1/3/46

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00783

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-6)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 days

Hospital, Institution, or street address where death occurred:
Washington Sanitarium and Hospital

How long in hospital or institution? 57 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: New Jersey County: Union

City or town: Plainfield
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D. #2
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Tobiasson, Mrs. Lena Bruns

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cauc.	Widow

6.(b) Name of husband or wife: Thomas Tobiasson

Deceased 8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 31, 1888

8. AGE: Years	Months	Days	If less than one day
57	5	27	....hrs. ....min.

9. Birthplace: Elizabeth, New Jersey
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER 12. Name: ? Bruns

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Records - Washington Sanitarium & Hos

Address

17. Shipped (Burial, cremation, or removal? Which?) Date thereof Jan. 28 1946 (month) (day) (year)

Cemetery or crematory: Clover Leaf Mem. Pk.

Location: Union County Plainfield N.J.

18. Funeral director: W.W. Chamber

Address: 1400 Chapin St. N.W.

19. 1-27- 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January ~~28~~ 27 1946, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 30 1945, to ~~January 28~~ January 27 1946

and that I last saw her alive on January 25 1946

Immediate cause of death	DURATION
Acute auricular fibrillation with right heart dilatation.	12 hrs
Due to: Thyrotoxicosis	18 mos.
and	
Due to: Necrosis of liver	7 da.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: none

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John F. Bourneteyes M.D.
M. D. or other

Address: Takoma Park Date signed: 1/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (144c)

CERTIFICATE OF DEATH

011784

Reg. Dist. No. 2-16

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4304 East West Highway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: George Walter Turner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married.

6.(b) Name of husband or wife: Daisy H.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 29, 1900

8. AGE: Years	Months	Days	If less than one day
45			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Cable Splicer C & P. Telephone Co.
11. Industry or business:

FATHER
12. Name: William J. Turner
13. Birthplace: unknown

MOTHER
14. Maiden name: Va. Helen Conard
15. Birthplace: Maryland

16. Informant: Mrs. Daisy Turner
Address: 4304 East West Highway

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cemetery
Location: Frederick, Maryland

18. Funeral director: Wm Reuben Pumphrey
Address: 7557 Wis. Ave. Bethesda, Md.

19. 1/16/46 (Date rec'd by registrar) 19 46 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13 19 46, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 19 46, to Jan. 13 19 46, and that I last saw h alive on Jan. 13 19 46

Immediate cause of death	DURATION
Hemorrhage due to	2 min.
bullet wound Thru Skull	Inst.
Due to (Incident)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of 1-13-46
Where did injury occur? Bethesda (City or town) Monty (County) Md. (State)
Injured at home, farm, Industry, public place (where?): woods
Means of injury: 22 cal. bullet Injured at work? no

23. SIGNATURE: Frank J. Broschart M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed: 1-14-46

M

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

00785

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one month 16 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 month, 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 38 Buchanan St., N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: VINICUR, Samuel (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Anna E. Vinicur
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-25-93

8. AGE: Years	Months	Days	If less than one day
52	0	26	hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: veteran
11. Industry or business:
FATHER 12. Name: Morris Vinicur
13. Birthplace: Russia
MOTHER 14. Maiden name: Ethel Rosen
15. Birthplace: Russia
16. Informant: wife: Mrs. Anna E. Vinicur
Address: 38 Buchanan St., N.E., Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof 1-23-46 (month) (day) (year)
Cemetery or crematory: Brin Amel
Location: Oak Hill, Md
18. Funeral director: Bernard Danzansky & Sons Co.
Address: 3501 14th St., N.W., Wash., D.C.
19. 1-21 (Date rec'd by registrar) 19 46 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 January 19 46 at 3:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Dec. 19 45, to 21 Jan 19 46
and that I last saw him alive on 21 Jan 19 46

Immediate cause of death	DURATION
Myocardial Infarction	1 mo
Due to: Coronary Sclerosis	12 yrs
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: V. B. Ballard for R. A. CONARD, Lt. Cdr. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 1-21-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

Reg. Dist. No. 2 11 — 00786

1. PLACE OF DEATH:

County: Montgomery

City or town: Rural Damascus Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Damascus Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Alonza Claggett Watkins

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary D. Watkins

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 28. 1867

8. AGE: Years	Months	Days	If less than one day
78	5	27	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER — 12. Name: Edward King Watkins

13. Birthplace: Md.

MOTHER — 14. Maiden name: Sophronia R. Phelps

15. Birthplace: Md.

16. Informant: Paul W. Watkins

Address: Damascus Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 27 1946 (month) (day) (year)

Cemetery or crematory: Damascus Md.

Location: Montgomery Co. Md.

18. Funeral director: Roy W. Barber

Address: Taylorsville Md.

19. Jan 24 1946 (Date rec'd by registrar) Della N. Burdette Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 24 19 46 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2nd Exam 19.. to 19.. 1946.

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute cardiac dilatation	Days
Due to: Chronic heart and renal disease	2 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockhart M.D. Dec. 2nd Exam. M. D. or other

Address: Gaithersburg Md. Date signed: 1-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

00787

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 hrs. 20 min.
Hospital, Institution, or street address where death occurred:
Washington Sanitarium & Hosp.
How long in hospital or institution? 28 hrs. 20 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 805 Carland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rosa Patterson West

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Caucasian	widowed

6.(b) Name of husband or wife Eugene Allen West (deceased)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 25, 1871

8. AGE: Years	Months	Days	If less than one day
74	10	15	..... hrs. ..... min.

9. Birthplace Kirksville Missouri (Town, county, and state)
10. Usual occupation —
11. Industry or business —
FATHER 12. Name Charles Patterson
13. Birthplace Sweden
MOTHER 14. Maiden name ?
15. Birthplace Sweden
16. Informant Records, Washington Sanitarium Daughter Mrs. F. E. Marsh
Address 805 Carland Ave, Takoma PK.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 14 1946. (month) (day) (year)
Cemetery or crematory Comstock Cemetery
Location Comstock, Wisconsin
18. Funeral director J. ARTHUR WALTERS
Address 254 CARROLL ST. N.W., TAKOMA PARK, 12, D.C.
19. Jan 10 1946 (Date rec'd by registrar) J. Arthur Walters Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10 1946, at 2:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/29/45 1945 to 1/10 1946 and that I last saw h... alive on 1/9/46 1946

Immediate cause of death — DURATION

(a) Hypostatic pneumonia — 2 da.
Due to (b) Cerebral hemorrhage, embolism — 2 days
Due to (c) Arteriosclerosis
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. H. Nolahan, M.D.
Address 500 Tidewood Ave. Date signed 1/10/46

M. D. or other

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on FILM No. 101 APR 3 - 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82-a)

CERTIFICATE OF DEATH

2nd CD

00788

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One year
Hospital, institution, or street address where death occurred: Home after sister, MacArthur Boulevard
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Wash. D. C. County: —
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1511-26th St. N.W. Wash. D.C.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Louise Annie Williams

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Colored	Widowed

6.(b) Name of husband or wife: Charles Williams
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 27-1875.

8. AGE: Years	Months	Days	If less than one day
71 - 70			..... hrs. ..... min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business
12. FATHER — Name: Lawson Garner
13. FATHER — Birthplace: Va
14. MOTHER — Maiden name: Mary C. Toney
15. MOTHER — Birthplace: Md
16. Informant: Mrs Emily R. Garner
Address: Mac. Arthur Boulevard

17. ..... Date thereof ..... (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location
18. Funeral director: W. Ernest Jarvis Co.
Address: 1432 - You Street N.W.
19. 1-23-46 19.. (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 23 - 46, at 2.20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 - 1945, to January 23 1946 and that I last saw h.er alive on January 19th 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days
Due to Arterio-sclerosis & hypertension.	4 years
Due to Age.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Wheeler D. Huff, M. D. or other
Address: Bethesda, Md. Date signed: Jan. 23 '46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-B)

CERTIFICATE OF DEATH

00789

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Cargo Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: WILLSON, Mary Ann

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband or wife: Lt. John Willson USN
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11-2-07

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
38	2	3		

9. Birthplace: N.Y.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: husband: Lt. JohnWillson USN
Address: 2 Cargo Green St., Wash., D.C.

17. cremation — Date thereof: 1-5-46 (month) (day) (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory: Ft. Lincoln
Location: Wash., D. C.

18. Funeral director: W. W. Chambers
Address: 517 11th St., S.E., Wash., D.C.

19. 1-5- 1946 Mary Charlotte Smith — Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 Jan 1946, at 9:55 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 28 Dec. 1945, to 5 Jan 1946 and that I last saw her alive on 5 Jan 1946

Immediate cause of death	DURATION
Rheumatic heart disease, decompensated	3 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Acute stenosis, rheumatic
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: T. S. BARNES, Lt.Comdr.(MC) USN
M. D. or other
Address: US NH, Bethesda, Md. Date signed: 1-5-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

(1/8/46)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00790

Reg. Dist. No. 714

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~X~~ or street address where death occurred: 2023 Lanier Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2023 Lanier Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Israel Deacon Yocum

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Abbie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 22nd. 1869

8. AGE: Years	Months	Days	If less than one day
76	1	4	..... hrs. ..... min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: U. S. Goverment employee

FATHER
12. Name: Edmond P. G. Yocum
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Martha Deacon
15. Birthplace: Pennsylvania

16. Informant: John P. J. Duhn,
Address: 2023 Lanier Drive, Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 28, 1946 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg, Maryland
18. Funeral director: Waxner C. Pumphrey
Address: Silver Spring, Maryland

19. Jan 26 1946 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 26, 1946 at 6 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 26 1945, to Jan. 26, 1946, and that I last saw h... alive on Jan. 26, 1946

Immediate cause of death	DURATION
Congestive Heart Failure	sudden
Due to: Mitral regurgitation	subacute
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: B Pettit M.D. M. D. or other
Address: 6911 Sligo Ave. Takoma Park, Md. Date signed: Jan 26, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (745)

CERTIFICATE OF DEATH

Reg. Dist. No. 00791 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital Bethesda, Md.

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give resideoce of mother)

State: ..... County: .....

City or town: Washington, D. C.

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 2966 North Hampton, N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3. (a) FULL NAME

Benjamin T. Yon.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Belueah Yon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 8 1891

8. AGE: Years	Months	Days	If less than one day
55	0	16	..... hrs. ..... min.

9. Birthplace: South Carolina (Town, county, and state)

10. Usual occupation: veteran

11. Industry or business: .....

FATHER

12. Name: Benjamin A. Yon

13. Birthplace: South Carolina

MOTHER

14. Maiden name: Annie Mims

15. Birthplace: South Carolina

18. Informant: Sister: Adolph DeLoy

Address: 55 W. 76th St., New York, N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-26-46 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. Chambers K. Langdon

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 1-25 19 46 Mary Charlotte Smith

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 19 46, at 4:45 pM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Myocardial Infarction	3 dys.
Due to: Coronary Sclerosis	20 yrs.
Due to: occlusion - (left ant desc) Coronary Sclerosis	1 wk. 2 days
Other conditions: Adenoma (Left Adrenal)	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: V. B. Ballard for R. A. CONARD, Lt. Cdr. (MC) USN

M. D. or other

Address: USNHBethesda, Md. Date signed 1-25-46